CONFIDENTIAL PATIENT INFORMATION

Date ______________________

PATIENT: Name ____
(Last) (First) (Middle) (Home Phone #)

Address ____
(Street) (City) (State) (ZIP)

Place of Employment ______________________ Occupation ______________

Business Address ____
(Street) (City) (State) (ZIP) (Business Phone#)

Date of Birth ______________________ SS# ______________ Male ❑ Female ❑

Height: ___ ft. ___ in. Weight _____ lbs. Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Hobbies ____

SPOUSE: Name ____
And Address if different from above

Place of Employment ______________________ Occupation ______________

Business Address ____

Person Responsible for Account ____
And Address if different from above

Whom may we thank for referring you to our office? ______________________

Has any member of your family been treated in our office previously? Yes ❑ No ❑ (Relationship) ______________

Why did you choose Dr. Sims as your dentist? ______________________

Reason for Visit: ____

DENTAL HEALTH: Please check one: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

What priority do you give your teeth (10 being highest)? 1 2 3 4 5 6 7 8 9 10

DENTAL INSURANCE: Please complete the following confidential information regarding Dental Insurance:

Primary Carrier Insurance Company ____

Mailing Address ____

Employee ______________ SS# ______________ Group# ______________

Secondary Carrier Insurance Company ____

Mailing Address ____

Employee ______________ SS# ______________ Group# ______________

MEDICAL HEALTH: Please check one: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Physician's Name ____

Last complete physical? ______________ Are you under a doctor's care now? ______________

If yes, for what reason? ____

Please list any medications, pills or drugs you are taking ______________________

____

Have you ever received a blood transfusion? Yes ❑ No ❑ When? ______________________

Are you subject to fainting spells? Yes ❑ No ❑ Are you pregnant? Yes ❑ No ❑ How long? ______________

Are you subject to prolonged bleeding? Yes ❑ No ❑

(over)

MEDICAL HEALTH: (continued)

Are you allergic to: ❑ Penicillin ❑ Codeine ❑ Local anesthetics ❑ Other medications - list below:

____

Please CIRCLE if you have or have had any of the following:

Heart Trouble	Fainting or Dizziness	Hepatitis B (serum)
High Blood Pressure	Stroke	Recent Weight Loss
Low Blood Pressure	Diabetes	Cancer
Heart Murmur	Artificial Joints/Hips	Thyroid Disease
Rheumatic Fever	Kidney Trouble	Parathyroid Disease
Congenital Heart Lesion	Ulcers	X-Ray or Cobalt Tmt.
Artificial Heart Valve	Allergies	Chemotherapy/Radiation
Heart pacemaker	Asthma	Arthritis/Gout
Heart Surgery	Hay Fever	Glaucoma
Mitral Valve Prolapse	Sinus Trouble	Epilepsy or Seizures
Blood Disease	Emphysema	Alzheimer's Disease
Anemia	Frequent Cough	Hypoglycemia
Chest Pain	Lung Disease	Psychiatric Care
Shortness of Breath	Liver Disease	Hemophilia
Swelling of Feet/Ankles/Hands	Hepatitis A (infec.)	HIV Positive

Have you ever had any serious illness not circled above? ❑ Yes ❑ No Please describe in detail. ____________

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Do you wish to talk to the doctor privately about any problem? ❑ Yes ❑ No

I will allow Dr. Sims to photograph and use for educational purposes any aspect of my dental conditions or treatment procedures, and further will allow him permission to discuss my conditions with my physician and to request medical information from him.

____ **Patient's Signature**

____

Reviewed by: Doctor ______________________________ Date ____________

MEDICAL UPDATES:

I have read my MEDICAL HISTORY dated ____ and confirm that it adequately states past and present conditions.

Date	Exceptions		Patient's Signature	Reviewed By
______	____________________	None ❑	____________________	______________
______	____________________	None ❑	____________________	______________
______	____________________	None ❑	____________________	______________
______	____________________	None ❑	____________________	______________
______	____________________	None ❑	____________________	______________
______	____________________	None ❑	____________________	______________
______	____________________	None ❑	____________________	______________
______	____________________	None ❑	____________________	______________
______	____________________	None ❑	____________________	______________
______	____________________	None ❑	____________________	______________