INFORMATION REQUIRED FOR CASE HISTORY RECORD
THIS COMPLETE CONFIDENTIAL RECORD IS IMPORTANT FOR OUR RECORDS AND YOUR HEALTH

Have your even been a patient in this office before? YES ☐ NO ☐ Approximate date: ____________________

PATIENT: ________________________________ NICKNAME:________ DATE:____________________

Residence Address:____

Phone:____________________ City: ____________________ Zip Code: ________________________

CIRCLE ONE: MISS MRS. MS. MR. DR. REV. SINGLE MARRIED SEPARATED DIVORCED WIDOWED

If you are 18 or older and a student please list: School __________________ Units/Credits: ________________

Date of Birth: _________ Age: _____ Social Security #: ______________ Driver's Lic #: __________________

Occupation: ______________________________ Employer: ________________________

Business Address: ________________________________ **City:** __________________ **Phone:** ________

Phone number where you can be reached during the day: ____

IF PATIENT IS MARRIED COMPLETE THIS PORTION

Spouse's Name: ____

Spouse's Occupation: ____________________________ Soc Sec #: ____________

Spouse's Employer: ______________________________ Phone: ______________

Address: ______________________________________ City: ________________

IF PATIENT IS A SINGLE MINOR (under 21 years) COMPLETE THIS PORTION

Parent or Guardian's Name:______________________ Driver's Lic #: ______________

Person Financially Responsible: __________________ Soc. Sec. #: ________________

Occupation: ________________________________ Employer: __________________

Address: ________________________________City: ____________Phone: __________

Name of nearest person not living with you: ______________________________Relationship:____________

Address: ____ Phone: ________________

ALL PATIENTS

Physician: ____M.D

City: ________________________________ Phone: ________

Dentist:____D.D.S.

City: ________________________________ Phone: ________

Orthodontist: ____________________________________D.D.S

City: ________________________________ Phone: ________

PLEASE PRINT the name of person or Doctor who referred you to this office:
Name:____ Address: ____

Insurance Information:

Medical____________________	Primary Dental Ins __________________	Secondary Dental __________________
Address ____________________	Address ________________________	Address ________________________
Name of Policy Holder __________	Name of Policy Holder ____________	Name of Policy Holder ____________
Birthdate of Policy Holder_________	Birthdate of Policy Holder __________	Birthdate of Policy Holder __________
S.S of Policy Holder ____________	S.S of Policy Holder ______________	S.S of Policy Holder ______________

PLEASE TURN AND COMPLETE HEALTH HISTORY RECORD ON REVERSE SIDE

HEALTH HISTORY

PLEASE ANSWER EACH QUESTION BY CHECKING THE "YES" OR "NO" COLUMN

1. Are you now in good health?______________________________
   a. In not what medical conditions do you have?___________________________________
2. My last physical examination was on ____
3. What operations have you had?____
4. Do you now or have you ever had any serious illness or conditions such as: (please circle)

YES	NO	HEPATITUS	YES	NO	HIGH BLOOD PRESSURE
YES	NO	RHEUMATIC FEVER	YES	NO	STROKE
YES	NO	HEART MURMUR	YES	NO	DIABETES
YES	NO	KIDNEY DISEASE	YES	NO	HIV POSITIVE
YES	NO	EPILEPSY	YES	NO	THYROID CONDITION
YES	NO	HEART DISEASE	YES	NO	LUNG DISEASE, ASTHMA

5. Please give details on any yes answers above:____
6. Please list those medicines or drugs you take regularly or use: ______________________________________
7. Please list those medicines or materials you are allergic to (ie. Penicillin, Tetracycline, Aspirin, latex)

   ____

YES	NO	8. Have you ever received radiation or Chemotherapy treatment for a tumor or growth of the head or neck?
YES	NO	9. Do you have any infectious diseases (HIV, Hepatitis, etc) or condition If Yes, explain
YES	NO	10. Do you now have or have you ever had any heart trouble?(heart attack, heart failure, coronary insufficiency, coronary occlusion, etc).
YES	NO	11. Do you have chest pain on exertion (angina)?
YES	NO	12. Are you short of breathe on mild exertion?
YES	NO	13. Do your ankles ever swell?
YES	NO	14. Do you have a bleeding disorder?
YES	NO	15. Has a doctor ever said you had liver disease, jaundice or hepatitis?
YES	NO	16. Have you ever had psychiatric treatment?
YES	NO	17. Do you smoke? If "YES" how many packs per day? _________ For how long? ______Yrs.
YES	NO	18. Do you now have a cold, cough or chest congestion?
YES	NO	19. Do you regularly have a cough?
YES	NO	20. Do you have lung disease (TB, emphysema)?
YES	NO	21. Have you ever taken the drug Phen-Phen, Redux or and Diet drugs?
YES	NO	22. Do you have any disease, condition or problem not listed above that you think we should know about? ____
YES	NO	23. Do you wear contact lenses?
YES	NO	24. Do you use alcohol, cocaine or marijuana regularly?
YES	NO	25. Women- Are you pregnant at the present time?

I CONFIRM AS TRUE THE ABOVE HEALTH HISTORY INFORMATION. I UNDERSTAND THAT AN ACCURATE HISTORY IS ESPECIALLY IMPORTANT IS ANESTHESIA IS CONTEMPLATED.

Signature ____ Date:_______________