

JAMES W. RHEA D.D.S. MICHAEL J. DOHERTY D.D.S.

Patient Information

Name: _____ Sex: _____ Social Security #: _____
Address: _____ City _____ State _____ Zip _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____ Birth Date: _____
Occupation: _____ Employer: _____ Address: _____
Spouse's Name: _____ Employer: _____
Who is responsible for this account? _____ Relationship: _____
Primary Dental Insurance: _____ Policy or Member #: _____
Secondary Dental Insurance: _____ Policy or Member #: _____
How did you learn of our office? _____

Medical History

Physician: _____ Approximate date of last physical: _____
Are you under any medical treatment now? _____ If so, for what? _____
Are you taking any drugs or medications? _____ If so, what? _____
Have you had any major operations? _____ If so, for what and when? _____
Are you allergic to anything? _____ If so, what? _____

Has anyone informed you that you had:

	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
A heart ailment?	_____	_____	Heart murmur?	_____	_____
High blood pressure?	_____	_____	Mitral valve prolapse?	_____	_____
Respiratory disease?	_____	_____	Rheumatic fever?	_____	_____
Diabetes?	_____	_____	Blood disease?	_____	_____
Yellow jaundice or hepatitis?	_____	_____	Tumors or growths?	_____	_____
HIV infection or AIDS	_____	_____	If so, where? _____		
Joint (Hip or Knee) Replacement	_____	_____			

Women: Are you pregnant, breast-feeding, or taking birth control pills? _____ YES NO

Dental History

Have you ever had any unusual reactions to local anesthetic? _____ YES NO
When was the last time you saw a dentist for treatment? _____
Do you feel there is anything else your doctor needs to know about your medical or dental condition? _____

(Payment is due at time of service unless previous arrangements have been made. Collection fees will be added to accounts not kept current.)

Signature: _____ **Date:** _____
updated: _____