PERSONAL INFORMATION - HEALTH HISTORY
Comprehensive Exam

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NAME _____ **Birthdate**:_____ Social Security no._____

MAILING ADDRESS_____City/State/Zip_____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

Who can we thank for your referral? _____

PHONES: Home: _____ Work: _____ FAX: _____

Cell: _____ pager: _____ email: _____

OCCUPATION:_____ **EMPLOYER** & address_____

Spouse's **Name**_____ **EMPLOYER** & address_____

ACCOUNT RESPONSIBILITY if someone other than yourself: NAME_____

Their Social Security No.: _____ Occupation:_____

Emergency contact number_____ Daytime Phone_____

INSURANCE : If you have dental insurance, we will provide you with receipt documentation than can be attached to your insurance company form for proper filing. You will receive a reimbursement directly for whatever you are entitled to. **The most important thing for you to know is the amount of your "calendar year maximum"** which you can find by calling your insurance carrier.
I understand that I will be charged a minimum of $127 for any cancelled, failed or missed appointment when notifying the office less than 48 business hours.

HEALTH HISTORY (please check if you have or had any of the following:)

☐ Yes ☐ No	Are you in good health?	☐ Yes ☐ No	Diabetes
☐ Yes ☐ No	Has your health changed in the last year	☐ Yes ☐ No	Tumors, cancer
☐ Yes ☐ No	Chest pain, shortness of breath	☐ Yes ☐ No	Radiation treatment
☐ Yes ☐ No	Bleeding problems, bruise easily	☐ Yes ☐ No	Psychiatric care
☐ Yes ☐ No	Headaches, ringing in ears	☐ Yes ☐ No	Kidney or bladder disease
☐ Yes ☐ No	Joint pain or stiffness, arthritis	☐ Yes ☐ No	VD, herpes
☐ Yes ☐ No	Fainting or seizures	☐ Yes ☐ No	HIV positive, AIDS, ARC
☐ Yes ☐ No	Heart disease, murmurs, rheumatic fever, prosthetic heart valve	☐ Yes ☐ No	Pregnant: month_____
☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Birth control Pills
☐ Yes ☐ No	High Blood pressure	☐ Yes ☐ No	Smoking / alcohol
☐ Yes ☐ No	Hepatitis or liver disease		_____BP _____Pulse
☐ Yes ☐ No	TB, asthma or lung disease		

List any and all **ALLERGIES:**_____

List any and all **DRUGS/MEDICATIONS** you are taking:_____

List any and all **SURGERIES:**_____

☐ Yes ☐ No Are you being treated by a Doctor now? Who?_____

The above information is true and correct to the best of my knowledge:

PATIENT SIGNATURE: _____ DATE:_____