MEDICAL HISTORY

Your Chief Oral Complaint: ____

Are you currently under the care of a physician? Yes______ No______ Are you Pregnant at this Time? Yes______ No ______

Describe any current medical treatment including drugs taken:____________________________

Physician's Name ______________________________Physician's Telephone: ____________________

Physician's Address: ____________________________Date of last physical exam:________________

Have you ever had an allergic or unusual reaction to a local anesthetic? Yes______ No______

Explain: ____

Are you allergic to or have your reacted adversely to any of the following medications?

ASPIRIN ERYTHROMYCIN PENICILLIN NITROUS OXIDE CODEINE

Are you allergic to any other medications? Yes______ No______

Explain: ____

____

____

*Please check (✓) if you had any of the following:

______Heart Failure
______Heart Disease or Attack
______Angina Pectoris
______High Blood Pressure
______Heart Murmur
______Rheumatic Fever
______Congenital Heart Lesions
______Artificial Heart Valve
______Mitral Valve Prolapse
______Heart Pacemaker
______Heart Surgery
______Artificial Joints (Hip, Knee)
______Anemia
______Stroke
______Kidney Trouble
______Ulcers

______Emphysema
______Chronic Bronchitis
______Tuberculosis (TB)
______Asthma
______Hay Fever
______Sinus Trouble
______Allergies or Hives
______Diabetes
______Thyroid Disease
______Radiation Treatment
______Chemotherapy (Cancer, Leukemia)
______Arthritis
______Cortisone Medicine
______Pain in Jaw Joints
______Venereal Disease (Syphillis, Gonorrhea)
______Bruise Easily

______A.I.D.S/A.R.C./HIV Pos.
______Hepatitis A (infectious)
______Hepatitis B (serum)
______Liver Disease
______Yellow Jaundice
______Blood Transfusion
______Drug or Alcohol Abuse
______Hemophilia (Bleeding Problems)
______Fever Blisters
______Genital Herpes
______Epilepsy or Seizures
______Fainting or Dizzy Spells
______Nervousness
______Psychiatric Treatment
______Sickle Cell Disease
______Alcoholism

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GENERAL INFORMATION

Patient's Last Name:______________________________First ______________________Middle_______S.S.#________________

Address: ____City: ______________________State: _______Zip Code: _____________

Home Phone: ______________________Male [ ] Female [ ] Date of Birth: _________________ Single [ ] Married [ ]

Cell Phone:____ Parent [ ] Guardian [ ]

EMPLOYER: ____

Address: ____City: ______________________State: _______Zip Code: _____________

Employer's Phone: ______________________________

If married, spouse's name: ____S.S.# _______________________

Spouse's Employer:____Phone:______________________

Whom may we thank for referring you to our office:____

Responsible Party - Check here if same as patient [ ]

Bill Account To: ____Relationship: _________________

Address: ____________________________________ City: ______________________ State:______ Zip Code: ______________

Phone: ____Responsible Party's S.S. #_______________________

If the patient is a child, name of school:____City: _________________________

Father's Name: ____S.S.# ________________________

Father's Employer: ____Phone: ______________________

Mother's Name: ____S.S.# ________________________

Mother's Employer:____Phone: ______________________

DENTAL INSURANCE INFORMATION:

Primary Dental Insurance: ____Deductible $__________________

Policy #:_______________________________________Address: ____

Group #: ______________________________________Effective Date: _____________________________

Subscriber's Name:_____________________________D.B.__________________Insurance Phone:_________________________

Secondary Dental Insurance: ____Deductible $ _________________

Policy #:_______________________________________Address: ____

Group #: ______________________________________Effective Date: ___________________________

Subscriber's Name:_____________________________D.B.__________________Insurance Phone:_________________________

OFFICE POLICY

I understand that I am fully responsible for payment of any fees incurred at this office. I agree to pay for services on the day they are performed unless I make other arrangements with the business manager. These include: 5% cash discount for accounts over $1000.00 paid in full on the day treatment begins – or 1/2 balance at beginning of treatment and remaining half due upon completion of treatment. Visa, Mastercard, and Care Credit Card (available through application) are accepted. Any balance that is overdue by 90 days will be turned over to a collection agency.

Signed: ____Date: __________________________________

I hereby authorize any needed treatment and the release of any information regarding this treatment for the purpose of obtaining insurance benefits.

Signed: ____Date: __________________________________

I hereby authorize payment directly to Dr. Robert J. Barnett of the insurance benefits otherwise payable to me.

ROBERT J. BARNETT, D.D.S.

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