MARK S. MOORE, D.D.S.

PATIENT INFORMATION

PATIENT _____ **AGE** _____ **BIRTHDATE** _____

ADDRESS _____ **PHONE** _____
street city state zip code
CELL _____

SOCIAL SECURITY NO. _____ **DRIVER'S LICENSE #** _____

EMPLOYER _____

EMPLOYER ADDRESS _____ **BUS. PHONE** _____
street city state zip code

SPOUSE / PARENT _____ **DOB** _____

SPOUSE'S / PARENT'S EMPLOYER _____ **PHONE** _____

SPOUSE'S / PARENT'S SOCIAL SECURITY NO. _____

RESPONSIBLE PARTY IF CHILD _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

DO YOU HAVE DENTAL INSURANCE? _____ **IF SO, NAME OF COMPANY** _____

Group Number _____ **Certificate Number** _____

If Group, With Whom? _____ **Member's Name** _____

If more than ONE Dental Insurance: _____

NAME OF COMPANY _____

Group Number _____ **Certificate Number** _____

If Group, With Whom? _____ **Member's Name** _____

UNLESS PRIOR ARRANGEMENTS ARE MADE
ALL BILLS MUST BE PAID AT THE TIME THAT SERVICES ARE RENDERED.

Physician's Name _____ Date of Last Physical _____

Date of Last Dental Visit _____

Have you ever had any of the following? (check boxes that apply):

- ☐ Heart Problems
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Problems
- ☐ Nervous Problems
- ☐ Radiation Treatment
- ☐ Artificial Heart Valves or joints
- ☐ Recent Weight Loss
- ☐ Back Problems
- ☐ Diabetes
- ☐ Respiratory Disease
- ☐ Headaches
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Cancer
- ☐ Psychiatric Care
- ☐ Chronic Diarrhea
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicine or Drugs
- ☐ General Allergies
- ☐ Blood Disease
- ☐ Arthritis
- ☐ Mitral Valve Prolapse
- ☐ Latex Allergy
- ☐ Swollen Neck Glands
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ "A.I.D.S." or Other immunosuppresive Disorders
- ☐ Stroke
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Chemical Dependency
- ☐ Hemophilia
- ☐ Epilepsy

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____ If so, what _____

_____

Have you ever responded adversely to medical or dental treatment? _____

Are you taking any medication at this time? _____ If so, what _____

Are you under the care of a physician? ☐ Yes ☐ No

For what conditions? _____

If patient is a child, what is his/her weight? _____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Taking Birth Control? ☐ Yes ☐ No Hormones ☐ Yes ☐ No

Is there anything we should know about your medical history? _____

_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in completion of this form.

Date _____ Signature _____