Hello! Welcome to our office!

In order to serve you promptly, we will need the following information. All information will be strictly confidential.

Date: _____

Michael G. Stevens, D.D.S.
Practice limited to endodontics

Patient Information

Name: ○ Ms. ○ Mr. ○ Mrs. ○ Dr. _____
Last First MI Name Preference

Address: _____

City: _____ State: _____ Zip Code: _____

○ Single: ○ Married: ○ Widowed: ○ Separated: ○ Divorced

Social Security No.: _____ Home Phone: _____ Work: _____ Cell: _____

Date of Birth: _____ Sex: ○ M ○ F Spouse's Name: _____

Your Employer: _____ Employer's Address: _____

Whom may we thank for referring you? _____ General Dentist: _____

In case of emergency, who should be notified? _____

Phone Number: _____ **Relationship**: _____

Billing Information (if different from above)

Name of Responsible Party: _____ Relationship to Patient: _____
Last First MI

Address: _____ City: _____ State: _____ Zip Code: _____
(If PO Box, give street address also)

Home Phone: _____ Work Phone: _____

Form of Payment

Payments for office visits are due at the time of treatment, including your estimated insurance portion. We would be happy to answer any questions you may have.

We accept the following: ○ Cash ○ Check ○ Mastercard ○ Visa ○ Discover ○ American Express

Insurance

Do you have dental insurance? ○ No ○ Yes
(Please furnish insurance information on your first visit.)

Name of Insurance Company: _____ Group Number: _____

Address of Insurance Company: _____ Phone Number: _____

Name of Insured Person (Employee): _____

Social Security No.: _____

Employer: _____ Date of Birth _____

Secondary Insurance Information

Name of Insurance Company: _____ Group Number: _____

Address of Insurance Company: _____ Phone Number: _____

Name of Insured Person (Employee): _____

Social Security No.: _____ Date of Birth: _____

Employer: _____

I, _____, have read a copy of the office's **Notice of Privacy Practices**.

Signature _____ Date _____

Please continue to the reverse side and complete.

Medical History

Physician Office _____ Last physical _____ Last visit _____

DO YOU HAVE OR EVER HAD?
(Circle all those that apply, write in others)

Oral/Dental: (inflamed areas, growths, sore spots, pain in jaw, loose teeth, removable dental appliance)
❑ Yes ❑ No

Eye, Ear, Nose, Throat problems: (glaucoma, lens implant, sinus problems, hay fever, contact lenses)
❑ Yes ❑ No

Heart Problems: (chest pain, angina, eart attack, congestive heart failure, irregular heart beat, pacemaker, heart valve replacement, damage, prolapse or heart murmur, rheumatic fever, heart bypass surgery)
❑ Yes ❑ No

Lung problems: (asthma, emphysema, tuerculosis, bronchitis, chronic cough, abnormal chest x-ray, sleep apnea)
❑ Yes ❑ No

Vascular problems: (high blood pressure, low blood pressure, leg bypass surgery)
❑ Yes ❑ No

Intestinal problems: (acid reflux, hiatal hernia, hepatitis, cirrhosis ulcers, intestinal bleeding)
❑ Yes ❑ No

Genitourinary problems: (kidney disease or failure, dialysis prostate problems)
❑ Yes ❑ No

Could you be pregnant? Are you nursing?
❑ Yes ❑ No

Muscle/bone problems: (back problems, neck problems, arthritis, TMJ, joint problems, artificial joints)
❑ Yes ❑ No

Skin problems: (rash, hives, open sores)
❑ Yes ❑ No

Nervous system problems: (seizures, paralysis, numb areas, stroke, weakness, migraines, confusion, fainting, anxiety, depression, bipolar disorder, dementia, Alzheimer's, autism)
❑ Yes ❑ No

Endocrine problems: (diabetes, thyroid, low blood sugar)
❑ Yes ❑ No

If diabetic, controlled by: diet, oral medications, insulin
Anemia, bleeding problems, transfusions, blood thinners
❑ Yes ❑ No

Immune system problems: (rhuematoid arthritis, lupus, HIV)
❑ Yes ❑ No

Cancer/Chemotherapy/X-Ray Treatment
❑ Yes ❑ No

ALLERGIES ❑ None

Are you allergic to, or have you ever had an adverse reaction to:
• Latex or rubber products? ❑ Yes ❑ No
• Other allergies to medications? Please list:

Medication _____ Reaction _____
Medication _____ Reaction _____
Medication _____ Reaction _____

MEDICATIONS Please List: ❑ None
(include over-the-counter and herbal medicatons)

_____ dose/frequency _____
_____ dose/frequency _____
_____ dose/frequency _____
_____ dose/frequency

PREVIOUS SURGERIES/HOSPITALIZATIONS/YEAR
anesthetic problems/family history/muscle weakness/high fevers after anesthesia
❑ Yes ❑ No

Have you ever taken bisphosphonate medications for your bones? (Fosamax, Actonel, Boniva, or Zometa)
❑ Yes ❑ No

DO YOU HAVE any other disease, condition or problem not listed above that you tink the doctor should know about?
❑ Yes (explain) ❑ No

NOTICE:
If you are on birth control pills, be advised that antibiotics interfere with the birth control pill & lessen its effectiveness. Use other precautions until your next menstraul period.

Signature of Person Completeing Health History _____ Date _____

Doctor's Initials _____ Date _____

Medical Update: I have reviewd my health history and confirm that it adequetely states past and present conditions.

Exceptions or Changes _____ Date _____

Patient's Signature _____ Doctor's Initials _____

Exceptions or Changes _____ Date _____

Patient's Signature _____ Doctor's Initials _____