

PERSONAL INFORMATION - HEALTH HISTORY:

NAME _____ Birthdate: _____ Social Security # _____

MAILING ADDRESS _____
(City) (State) (Zip)

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE: _____

PHONES: Work: _____ Home: _____ Fax: _____
Cell: _____ Email: _____

OCCUPATION: _____ EMPLOYER & Address: _____

Spouse's OCCUPATION: _____ EMPLOYER & Address: _____

ACCOUNT RESPONSIBILITY if someone other than yourself: NAME _____

Their Social Security #: _____ Birthdate: _____

Mailing Address: _____ Daytime Phone: _____

Do you have Dental Insurance? _____ If so, please provide us with your insurance card so we may copy it for our records.

INSURANCE: If you have dental insurance, we will provide you with receipt documentation that 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.

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

<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you in good health?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has your health changed in the last year
<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest pain, shortness of breath
<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding problems, bruise easily
<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches, ringing in ears
<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint pain or stiffness, arthritis
<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or seizures
<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart disease, murmurs, rheumatic fever, prosthetic heart valve, irregular heartbeat
<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker
<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood pressure
<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis or liver disease
<input type="checkbox"/> Yes <input type="checkbox"/> No	TB, asthma or lung disease

<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes
<input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Medicine
<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, cancer
<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation treatment
<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression
<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney or bladder disease
<input type="checkbox"/> Yes <input type="checkbox"/> No	Coldsores, Feverblisters, Herpes
<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV positive, AIDS, ARC
<input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant: month _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Birth control Pills
<input type="checkbox"/> Yes <input type="checkbox"/> No	Recreational drugs smoking/ alcohol
<input type="checkbox"/> Yes <input type="checkbox"/> No	Latex Allergies

Do you require any PRE MEDICATION before your dental treatment? _____

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. Since Dr. Norton lectures extensively I authorize him to use my case and photographs for teaching or promotional purposes.

PATIENT SIGNATURE: _____ DATE: _____