

Craig A. Mayer, D.D.S.

PATIENT INFORMATION FORM

TODAY'S DATE _____

Last Name _____ First _____ MI _____ Nickname _____

Street Address _____

City _____ State _____ Zip _____

Out of State Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Soc. Sec. # _____

Single _____ Married _____ Widowed _____ Divorced _____

Physician _____ Phone _____

Physician's Address _____

In Case of Emergency Notify (Not Living With You)

Last Name _____ First _____

Address _____ Phone _____

Dental Insurance Information

Primary Insurance _____ ID# _____

Address _____ City _____ ST _____ Zip _____

Phone _____ Name of Insured _____

Who is Financially Responsible for this Bill _____

I will be paying by Cash _____ Check _____ Credit Card _____

Please Complete the Following Information:

Where Are You Employed _____

Spouses Name _____

Where is S/He Employed _____ Phone _____

Who Can We Thank for Referring You To Us

Name _____ Phone _____

Address _____ City _____ ST _____ Zip _____

Yellow Pages _____ Newspaper _____ Drive By _____

MEDICAL HISTORY

CIRCLE

1. Are you having pain or discomfort at this time?.....YES NO
2. Do you feel very nervous about having dental treatment?YES NO
3. Have you ever had a bad experience in the dental office?YES NO
4. Have you been a patient in the hospital during the past two years?YES NO
5. Do you have swelling in the roof of your mouth?YES NO
6. Have you noticed purplish color on your gums or cheeks?YES NO
7. Do your gums bleed sometimes?YES NO
8. Have you been under the care of a medical doctor during the past two years?YES NO

If so why? _____

9. Have you taken any medicine or drugs during the past two years?YES NO
- Are you now taking any medication, drugs or pills?YES NO
- If yes, please list those drugs: _____

10. Are you allergic or have you reacted adversely to any of the following medications: (Please **Circle** if yes)

Aspirin	Nitrous Oxide	Scopolamine	Penicillin
Codeine	Erythromycin	Nembutal/Seconal	Other Antibiotics
Demerol	Valium	Sulfa Drugs	(Novocaine or Xylocaine)

11. Are you aware of being allergic to any other medication or substance?YES NO
- If yes, please list: _____

12. **Circle** any of the following which you have had or have at present:

Heart Failure	Cough	Hepatitis A (Infectious)	
Heart Disease or Attack	Tuberculosis (TB)	Hepatitis B (Serum)	Hepatitis C
Angina Pectoris	Asthma	Liver Disease	
High Blood Pressure	Hay Fever	Yellow Jaundice	
Heart Murmur	Sinus Trouble	Blood Transfusion	
Rheumatic Fever	Allergies or Hives	Drug Addiction	
Congenital Heart Lesions	Diabetes	Hemophilia	
Scarlet Fever	Thyroid Disease	Venereal Disease (Syphilis, Gonorrhea, Herpes)	
Artificial Heart Valve	X-ray or Cobalt Treatment	Cold Sores	
Heart Pacemaker	Chemotherapy (Cancer, Leukemia)	Fever Blisters - Herpes	
Heart Surgery	Arthritis	Epilepsy or Seizures	Rheumatoid
Anemia	Rheumatism	Fainting or Dizzy Spells	Arthritis
Stroke	Glaucoma	Nervousness	
Kidney Trouble	Pain in Jaw Joints	Psychiatric Treatment	Mitral Valve
Ulcers	Artificial Joints (Hip, Knee, Shoulder)	Sickle Cell Disease	Prolapse (MVP)
Emphysema	HIV/AIDS	Bruise Easily	

13. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired?YES NO
 14. Do your ankles swell during the day?YES NO
 15. Do you use more than 2 pillows to sleep?YES NO
 16. Have you lost or gained more than 10 pounds in the past year?YES NO
 17. Do you ever wake up from sleep short of breath?YES NO
 18. Are you on a special diet?YES NO
 19. Has your medical doctor ever said you have a cancer or tumor?YES NO
 20. Do you have any disease, condition, or problem not listed?YES NO
- Where _____ When _____

FOR WOMEN ONLY:

Are you pregnant? Yes No If yes, what month? _____. Are you taking birth control pills? Yes No

CONSENT:

The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, than may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine; due and payable at the time service is rendered. I further understand that a 1½% finance charge (18% annually) will be collected costs and reasonable attorney fees as may be required to effect collection of this note.

Patient _____ Date _____ Witness _____
 Parent of Responsible Party _____ Relationship to Patient _____