Richard S. Mowry, D.M.D.

PATIENT INFORMATION RECORD

THIS COMPLETE CONFIDENTIAL RECORD IS IMPORTANT FOR OUR RECORDS AND YOUR HEALTH

PLEASE PRINT THE FOLLOWING INFORMATION **(USE BLACK INK ONLY)**

Have you ever been a patient in this office before? NO_____ YES_____ When? 20 (_____)

PATIENT _____DATE _____

last name first middle

Residence Address_____Apt. #_____

street

City_____Zip Code_____Telephone ( )_____

Circle one: (Optional) Male Female Cell ( )_____

Date of Birth _____Age_____ Social Security # _____Driver's License #_____

Employer/School_____Occupation _____

Business Address_____City_____

Bus. Phone ( )_____Ext._____How Long Employed There? _____

FINANCIAL RESPONSIBILITY

Please complete if patient is a minor or person other than the patient is financially responsible.

Person Financially Responsible_____Relationship_____

Soc. Sec. # _____Driver's Lic. #_____

Home Address _____City_____Phone _____

Employer _____Dept. _____Occupation_____

Bus. Address _____City _____Phone_____

Parent or Guardian's Name _____

Mother's Full Name_____Phone_____

SPOUSE

If patient is married, please complete this portion.

Spouse's Name_____Soc. Sec. #_____

Spouse's Employer_____Dept. _____

Bus. Address_____City_____Bus. Phone _____

EMERGENCY NOTIFICATION

Name of nearest living relative

not living with you_____Relationship_____

Address_____City_____Phone _____

TREATING DOCTORS

All patient's, please complete

Physician: Dr._____City_____Phone _____

General Dentist: Dr. _____ City _____Phone _____

How Long:_____

Previous General Dentist: Dr._____ City _____Phone _____

How Long:_____

Orthodontist: Dr._____City_____ Phone _____

PROFESSIONAL REFERRAL

PLEASE PRINT the name of Doctor or Person who referred you to this office:

Name_____City_____

INSURANCE INFORMATION

Please provide complete medical & dental insurance information & insurance cards.

Do you have dental insurance?

____YES ____NO

1. INSURANCE COMPANY _____

POLICYHOLDER_____

EMPLOYER/COMPANY_____

SOC. SEC. #_____D.O.B._____

2. INSURANCE COMPANY _____

POLICYHOLDER_____

EMPLOYER/COMPANY_____

SOC. SEC. #_____D.O.B._____

Do you have medical insurance?

_____YES _____NO

1. INSURANCE COMPANY _____

POLICYHOLDER_____

EMPLOYER/COMPANY _____

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HEALTH HISTORY

PLEASE ANSWER EACH QUESTION BY CIRCLING "YES" OR "NO" & BRIEFLY EXPLAIN ANY "YES" ANSWER

YES NO 1. Are you in good health?
YES NO 2. My last physical examination was on: _____
YES NO 3. Has there been any change in your general health within the past year? If "YES," please explain: _____
YES NO 4. Are you now under the care of a physician? If "YES," please explain: _____
YES NO 5. Have you been hospitalized or had a serious illness within the past (5) years?
If "YES," please explain: _____

6. Do you know or have you ever had any serious illnesses or conditions such as: (Please circle "YES" or "NO")

YES	NO	Scarlet Fever	YES	NO	Frequent Severe Headaches	YES	NO	Diabetes
YES	NO	Rheumatic Fever	YES	NO	High Blood Pressure	YES	NO	Arthritis
YES	NO	Heart Murmur	YES	NO	Stroke	YES	NO	Thyroid Condition or Goiter
YES	NO	Anemia	YES	NO	Kidney or Bladder	YES	NO	Ulcers
YES	NO	Epilepsy			Disease or Infection	YES	NO	Mitral Valve Prolapse

YES NO 7. Have you been taking any prescription medications, vitamins, supplements or daily aspirin within the past year? If "YES," please list: _____
YES NO 8. Have you ever taken any prescription or over-the-counter diet pills? (Phen-Fen, etc.)? If "YES," please list: _____
_____
YES NO 9. Are you, or anyone in your family, sensitive or allergic to penicillin, aspirin, codeine, novocaine, general anesthetic (sleep) medications or any other drugs or medications? If "YES," please list & give reaction: _____
YES NO 10. Do you have difficulty with opening your mouth wide or with joint (TMJ) problems? If "YES," please explain: _____
YES NO 11. Do you wear any removable dental appliances (retainer, partial denture, dentures, etc.)? If "YES," please explain: _____
YES NO 12. Do you now have or have you ever had sinus trouble? If "YES," please explain: _____
YES NO 13. Have you ever had injury to your face or jaws? If "YES," please explain: _____
YES NO 14. Have you ever received radiation, chemotherapy or surgical treatment for a tumor, growth or cancer including IV medication for ostopenia or osteoporosis? If "YES," please explain: _____
YES NO 15. Have you ever had any lung disease, breathing difficulty, (asthma, emphysema, tuberculosis, pneumonia) a Persistant cough, or snore when asleep? If "YES," please explain: _____
YES NO 16. Do you now have or have you ever had any heart trouble? (heart attack, heart failure, coronary insufficiency, coronary occlusion, chest pains, etc.) If "YES," please explain: _____
YES NO 17. Do you have any reason to believe you may be immunosuppressed (chemotherapy, transplant surgery, etc.)? If "YES," please explain: _____
YES NO 18. Are you ever short of breath on mild exertion? If "YES," please explain: _____
YES NO 19. Do your ankles swell? If "YES," please explain: _____
YES NO 20. Have you ever had any excessive bleeding requiring special treatment? If "YES," please explain: _____
YES NO 21. Do you have any man-made materials implanted in your body? If "YES," please explain: _____
YES NO 22. Has a doctor ever said you had liver disease, jaundice, or hepatitis? If "YES," please explain:_____
YES NO 23. Do you have any numbness or tingling in any part of your body? If "YES," please explain:_____
YES NO 24. Are you subject to any nervous disorders, fainting or dizziness? If "YES," please explain: _____
YES NO 25. Have you ever had psychiatric treatment or attempted suicide? If "YES," please explain: _____
YES NO 26. Have you ever been treated for alcohol or drug abuse? If "YES," please explain: _____
YES NO 27. Do you smoke, drink alcoholic beverages or have you ever used drugs for recreational purposes? If "YES," please explain: _____
YES NO 28. Do you now have a cold, cough, or chest congestion? If "YES," please explain: _____
YES NO 29. Have you ever had anything to eat or drink in the last 6 hours? If "YES," ---What? _____What time ____ o'clock
YES NO 30. Do you wear contact lenses? If "YES," hard or soft lenses? _____
YES NO 31. Have you ever had a serious problem associated with any previous dental treatment? If "YES," please explain: _____
_____
YES NO 32. Do you have any disease, condition, or problems not listed above, allergies to latex or any other materials or have taken any medication for osteoporosis or osteopenia? If "YES," please explain:_____
YES NO 33. WOMEN---Are you pregnant at the present time? If "YES," how many months?_____months
34. Are you, or anyone in your family, sensitive or allergic to any foods such as soybeans, eggs, etc?
If yes, please explain._____

I hereby give Dr. Mowry permission to communicate and discuss my health history, as it pertains to my treatment, with other health care providers. I CONFIRM AS TRUE THE ABOVE HEALTH HISTORY INFORMATION.

Signature: _____ Date: _____
(Patient)

(_____) Signature: _____ Date: _____
assistant (Parent or Guardian if patient is a minor)

No changes in health or medications: _____Date:_____Signature:_____Date:_____