NEW PATIENT INFORMATION

Name _____ Age _____ Birthdate _____ Sex M❒ F❒
First Middle Last

Mailing Address _____ City _____ Zip Code _____

Single ❒ Married ❒ Divorced ❒ Widowed ❒ Home Phone _____

Patient's Social Security Number _____ Business Phone _____

Student Yes ❒ No ❒ School _____ Cell Phone _____

Employer / Position _____ Email _____

Has anyone in your household seen Dr. Webb? Yes ❒ No ❒ Whom? _____

Referred by _____ Previous Dentist _____ Last Visit _____

Person responsible for payment _____

Contact person in case of emergency _____ Phone _____

Do you have DENTAL INSURANCE? Yes ❒ No ❒ Sooner Care # _____

Subscriber/Employee Name _____ Relationship to Patient _____

Address _____

Home Phone Number _____ Work Phone Number _____

Date of Birth _____ Employee/Subscriber Social Security Number _____

Employer Name _____ Employee Position _____

PATIENT MEDICAL QUESTIONNAIRE

Yes	No		Yes	No	
❒	❒	Heart Trouble	❒	❒	Arthritis
❒	❒	Heart Murmur	❒	❒	Diabetes
❒	❒	Heart Valve Problem	❒	❒	Cancer
❒	❒	Heart Attack or Bypass	❒	❒	Epilepsy
❒	❒	Rheumatic Fever	❒	❒	Bleed Excessively
❒	❒	Prosthetic Joint	❒	❒	Smoker, dip, chew
❒	❒	High Blood Pressure	❒	❒	Asthma
❒	❒	Stroke	❒	❒	Emphysema
❒	❒	Hepatitis Type A,B,C,D,E	❒	❒	Thyroid Disorders
❒	❒	Other Illness	❒	❒	Osteoporosis, taken Biphosphonates? Fosomax, Boniva, Actinel,
❒	❒	Have you ever taken Fen Phen, Redux, or Pondimin?	❒	❒	Have you been exposed to HIV (AIDS)?
❒	❒	Are you pregnant?	❒	❒	Allergies to drugs, medicines, or injections?
❒	❒	Are you presently taking any medications?	❒	❒	If yes, please list _____

List _____

I hereby grant authority to Robert P. Webb, III, D.D.S., to administer any dental treatment, or to administer such anesthetics, as may be necessary to the diagnosis and treatment of this patient.

Signed _____ Relationship _____ Today's Date _____
(Patient, Parent or Guardian)

Remarks: _____