Beth Ann Faber, D.D.S.
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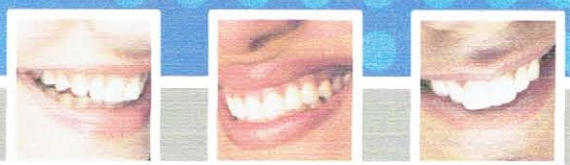

Patient Information

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Name of person, office or other source referring you to our practice:

_____

Spouse or Responsible Party Information

Name:

_____

Address:

_____

Contact telephone numbers?

_____

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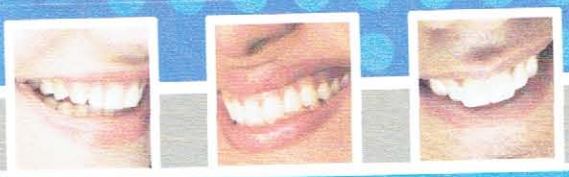

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____ _____

_____ _____ _____

City State Zip Code

Insurance Information

Primary Dental

Name of Insured: _____ _____ _____

Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Secondary Dental

Name of Insured: _____ _____ _____

Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

EMERGENCY CONTACT INFORMATION

Name:

_____

Phone (home,work,cell)

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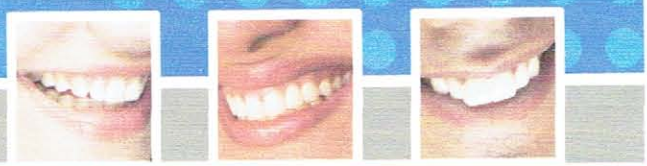

Family Physician (including phone number)

MEDICAL INFORMATION

Are you having any discomfort at this time?

◯ Yes ◯ No

Is your general health in excellent, good, poor or fair condition?

Date of Last Complete Physical Exam

Are you currently under the care of a physician due to a specific problem?

Please list any medications you are currently taking:

Please list any allergies you have:

Have you been told to take an antibiotic before dental treatment? If yes, why?

Do you currently take a blood thinner? If yes, why?

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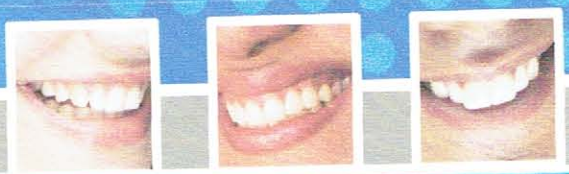

Are you sensitive to any medications, latex, anesthetic?

Do you smoke, chew tobacco? How long?

WOMEN

Are you pregnant? What is your due date?

Are you taking birth control pills?

Has a physician ever informed you that you have or have had any of the following?

- ☐ ADD/ADHD
- ☐ Asthma
- ☐ Cancer
- ☐ Cold Sores
- ☐ Drug Abuse History
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Head Injuries
- ☐ Hepatitis
- ☐ HIV
- ☐ Jaundice
- ☐ Liver Disease
- ☐ Arthritis
- ☐ Back Pain
- ☐ Chemo/Radiation
- ☐ Coumadin
- ☐ Drug Allergy
- ☐ Epilepsy/Siezures
- ☐ Fainting Spells
- ☐ Heart Disease
- ☐ Herpes
- ☐ Huntington's Disease
- ☐ Kidney Disease
- ☐ Mitral Valve Prolaps
- ☐ Artificial Joints
- ☐ Blood Disease
- ☐ Codeine Allergy
- ☐ Diabetes
- ☐ Dry Mouth
- ☐ Epinephrine Allergy
- ☐ Fever Blister
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Iodine Allergy
- ☐ Latex Allergy
- ☐ MS

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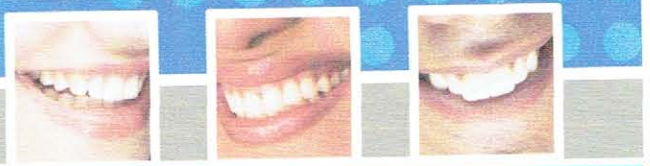

- [ ] Novocaine Allergy
- [ ] Penicillin Allergy
- [ ] Pre-Med
- [ ] Rheumatic Fever
- [ ] Stroke
- [ ] Tumors
- [ ] Other
- [ ] Periodontal Disease
- [ ] Psychiatric Care
- [ ] See Patient Note
- [ ] Sulfa Allergy
- [ ] Ulcers
- [ ] Pacemaker
- [ ] Pregnancy
- [ ] Respiratory Problems
- [ ] Sinus Trouble
- [ ] Tuberculosis
- [ ] Venereal Disease

Please list any other concerns or medical issues:

Who was your Previous Dentist?

CONSENT:

I hereby certify that all information indicated is correct to the best of my knowledge.

I understand that the office will assist in my dental insurance claim processing and my insurance company will reimburse me for dental services. I understand that payment for dental services provided by Dr. Faber and her team for my dependents and myself is my ultimate responsibility and due at the time of services.

Patient Signature (or parent if dependent is a minor)

Date