Richard E. Phelan, D.D.S.

Patient Information

Patient's Name _____ (Last) _____ (First) _____ (Middle) _____ (Nickname)

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Previous Address (If less than 3 yrs.) _____ (Street) _____ (City) _____ (State) _____ (Zip)

Home Ph. _____ Birth Date ____/____/____ Social Sec. # _____ Drivers Lic. # _____

Work Ph. _____ Cell # _____ E-mail Address _____

No. Years Employed _____ Marital Status _____ Male _____ Female _____

Employer _____ Occupation _____

Spouse's Name _____ (Last) _____ (First) _____ (Middle)

Spouse's Employer _____

Spouse's Occupation _____ Spouse's Work Phone _____

If patient is a minor, give parent's or guardian's name _____

Is an immediate family member a patient here? _____ Name _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Self _____ (Yes/No) Other _____ (Last) _____ (First) _____ (Middle)

If "other", please complete:

Social Sec. # _____ Birth Date ____/____/____ Relationship to Patient _____

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

How long at this address _____ Home Ph. _____ Work Ph. _____

Previous Address (if less than 3 yrs.) _____ (Street) _____ (City) _____ (State) _____ (Zip)

Dental Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____ Birth Date ____/____/____

Insured's Employer _____ Insured's ID# _____

Insurance Company _____ Group No. # _____ Phone # _____

Insurance Co. Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Do you have dual coverage? Yes ☐ No ☐ If yes:

Insured's Name _____ Insured's Soc. Sec. # _____ Date ____/____/____

Insured's Employer _____ Insured's ID# _____

Insurance Company _____ Group No. # _____ Phone # _____

Insurance Co. Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone ( ) _____

I understand that where appropriate, credit bureau reports may be obtained. I direct insurance benefits payable to the attending dentist.

Signature (Parent's signature, if minor) _____ Date _____

Updates (date & initial) _____ _____ _____ _____ _____

MEDICAL HISTORY

In the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you now under the care of a physician..... YES NO
   a. If so, what is the condition being treated? _____
2. The name and address of my physician is _____
   _____
   _____
3. Have you had any serious illness or operation?..... YES NO
   a. If so, what was the illness or operation? _____
4. Do you have or have you had any of the following diseases or problems?
   a. Rheumatic fever or rheumatic heart disease..... YES NO
   b. Congenital heart lesions..... YES NO
   c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke, mitral valve prolapse, murmur) ..... YES NO
   d. Asthma ..... YES NO
   e. Fainting spells or seizures ..... YES NO
   f. Diabetes ..... YES NO
   g. Hepatitis, jaundice, or liver disease ..... YES NO
   h. Inflammatory rheumatism (painful swollen joints) ..... YES NO
   i. Stomach ulcers ..... YES NO
   j. Kidney trouble ..... YES NO
   k. Tuberculosis ..... YES NO
   l. Low blood pressure ..... YES NO
   m. Venereal disease ..... YES NO
5. Have you had any abnormal bleeding associated with previous extractions, surgery, or trauma? ..... YES NO
6. Do you have any blood disorder such as anemia? ..... YES NO
7. Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your head or neck? ... YES NO
8. Are you taking any prescription or over the counter medications, vitamins, herbal supplements, etc... YES NO
   please list them: _____
9. List any allergies: medications, environmental, latex, food... _____
   _____
   _____
10. Have you had any serious trouble associated with any previous dental treatment? ..... YES NO
    If so, explain _____
11. Do you have any disease, condition, or problem not listed above that you think I should know about? .... YES NO
    If so, explain _____
    _____
12. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? ..... YES NO
13. Have you been tested for the AIDS virus? ..... YES NO
    If yes, please circle results ..... + -

WOMEN

14. Are you pregnant? ..... YES NO
15. Are you nursing? ..... YES NO

CHIEF DENTAL COMPLAINT:

_____
SIGNATURE OF PATIENT

_____
SIGNATURE OF DENTIST