PERSONAL INFORMATION RECORD

☐ Female ☐ Male

Full Name_____

Preferred Name_____ Date of Birth_____

Residence Address_____

Street City State Zip

Telephone (Home)_____ (Work)_____

In case of emergency, contact:_____ Phone#:_____

If different from above:

Responsible Party_____
Address_____
SS#_____ Date of Birth_____
Employer_____
Bus. Address_____
Bus. Phone_____
Dental Insurance Company's
Name_____
Address_____
Group#:_____ Policy#:_____

Spouse_____
Address_____
SS#_____ Date of Birth_____
Employer_____
Bus. Address_____
Bus. Phone_____
Dental Insurance Company's
Name_____
Address_____
Group#:_____ Policy#:_____

Whom may we thank for referring you to us?_____

HEALTH HISTORY

Patient's Primary Physician:

_____

Name City State Phone

Please list all medications you are currently taking_____

_____

Do you now, or have you ever had or used any of the following:

	Yes	No
Allergies, Especially To Local Anesthetics, Novocaine, Penicillin, Latex, Sulfa Drugs, Hay fever or Anything Else	_____	_____
Heart Disease, Attack, Surgery, Murmur, Infective Endocarditis	_____	_____
Heart Valve Diseases or Artificial Valves, Rheumatic Fever	_____	_____
Vascular Diseases, Stroke, Chest Pain, Hypertension, Hypotension	_____	_____
Nitroglycerin Pills	_____	_____
Lung Disorders or Diseases, Emphysema, C.O.P.D., Asthma, Bronchitis, T.B., Shortness of Breath, Sinus Infections	_____	_____
Nerve Disorders or Diseases, Seizures	_____	_____
Chronic Depression, Manic-Depressive, or Other Neurological or Psychological Disorders or Diseases	_____	_____
Eye Disorders or Diseases, Glaucoma	_____	_____
TMJ Problems, Grind or Clench Teeth, Ear Infections, Frequent Earaches	_____	_____

PLEASE TURN PAGE **OVER** AND ANSWER QUESTIONS ON THE BACK. THANK-YOU.

	Yes	No
Muscle Disorders or Diseases	_____	_____
Bone Disorders or Diseases, Osteoporosis	_____	_____
Ever used a Bisphosphonate, e.g., Fosamax, Actonel, Zometa, Boniva	_____	_____
Joint Disorders or Diseases, Arthritis, etc.	_____	_____
Artificial Limbs or Joints, Hip Replacement, etc.	_____	_____
Endocrine Disorders or Diseases, Hypo/Hyper Thyroid, Diabetes, Gout	_____	_____
Liver Diseases, Jaundice, Hepatitis, Gall Bladder	_____	_____
Blood Disorders or Diseases, Anemia	_____	_____
Tested Positive for HIV, AIDS	_____	_____
G.I. Diseases, Ulcers, Polyps	_____	_____
Urinary Tract, Kidney, Prostate, or G.U. Disorders or Diseases	_____	_____
Sexually Transmitted Diseases	_____	_____
Any Cancer or Tumor of Any Sort	_____	_____
Treated for Any Cancer or Tumor of Any Sort	_____	_____
Any Radiation Treatment To Head or Neck *(Does Not Include X-Rays Like a C.A.T. Scan, Dental Films etc..)*	_____	_____
I.V. Drugs, for Medicinal, Recreational, or Any Other Reasons	_____	_____
Alcohol	_____	_____
Tobacco	_____	_____
Hospitalized for Any Reason	_____	_____
Are you Currently Pregnant	_____	_____
Currently Using an Oral Contraceptive	_____	_____
Wearing Contact Lenses	_____	_____
Any Other Disorder or Disease That Has Not Been Mentioned	_____	_____

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance payments. The patient is responsible for all fees, regardless of insurance coverage.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize B.C. Nelson D.D.S. to furnish information to insurance carriers concerning my treatments, and I hereby assign to Dr. Nelson all payments for dental services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

I grant permission for any treatment photographs to be used for educational purposes.

I have read, understood, agreed to, and answered the above questions true to the best of my knowledge.

Signature:_____ Date_____

Date_____ B.P._____ P_____ T_____ R_____

Date_____ B.P._____ P_____ T_____ R_____

Date_____ B.P._____ P_____ T_____ R_____

Date_____ B.P._____ P_____ T_____ R_____

Notes or Updates: