

Patient Information Record

Date: ___/___/___

Patient Information										
Mr. Ms.		Name (First)			Middle			Last		
Date of Birth		Age		Social Sec #			Sex M F		Marital Status S M W D	
Address (Street)						City		State		Zip
Home Phone #				Work Phone #			Driver License #			
Employer/Occupation							If Student:		Full-Time	Part-Time
Employer's Address (Street)							City		State	Zip
General Dentist					Primary Physician				X-Rays	Y N
In Case Of Emergency, Please Notify					Relationship			Phone #		
Referred By					Name of Person Escorting You Home After Surgery					
Method of Payment Today: Cash <input type="checkbox"/> Check <input type="checkbox"/> MC <input type="checkbox"/> VISA <input type="checkbox"/> AMEX <input type="checkbox"/> Discover <input type="checkbox"/>										
Responsible Party or Spouse Information (if different from above)										
Name			Relationship to Patient				Soc Sec #			
Address (Street)						City		State		Zip
Home Phone # ()			Work Phone # ()			Driver Lic #		D.O.B		
Employer					Occupation					
Employer's Address						City		State	Zip	
Insurance Information - Primary Policy							Secondary Insurance? <input type="checkbox"/>			
Type Dental Medical Both		Plan Private HMO Medicare Medicaid Workers Comp PPO								
Name of Insured (Policy Holder)					Sex M F	D.O.B		Soc Sec #		
Relationship to Patient Self Spouse Dependent			Medicare #				Medicaid #			
Insurance Co.			Plan Name			Group #		ID #		
Ins. Carrier Address							Phone # ()			
Insured's Employer										
Employer's Address							Phone # ()			

Patient Medical History

Name of Patient: _____

Date: ____/____/____

Name of Primary Physician	Phone # ()
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Do you currently have or have you ever had any of the following?

- | | | | |
|--|--|-------------------------------------|--|
| Heart Attack | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood Transfusion | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bleeding Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation or Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rheumatics Fever or Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | AIDS or HIV Positive | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Abnormal Heart Rhythm | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sexually Transmitted Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures or Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tuberculosis or Consumption | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pneumonia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis or Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Do you currently have or have you ever had any of the following?

- | | |
|--|--|
| Recent weight loss or gain | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dizziness or fainting spells | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Recent cough or cold | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Easily fatigued after climbing a flight of stairs | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Awake frequently from sleep to urinate | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Shortness of breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest pain or Indigestion | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Swollen Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Use more than one pillow to sleep at night | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Taken steroids (Prednisone) medicines within the last two (2) years | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Patient Medical History

Name of Patient: _____

Date: ____/____/____

Please check this box if you have ever had any type of surgery

Please check this box if you have ever been under GENERAL ANESTHESIA

Type of Surgery

Year

General Anesthesia

Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No

Please check this box if you are currently taking any MEDICATIONS regularly

Name of Medication

Dosage (if known)

How long?

Please check this box if you are ALLERGIC to any medications

Please list medications that you are allergic to: _____

For Women -- Date of your last Menstrual Period: _____

Are you PREGNANT or believe you may be PREGNANT? Yes No

SIGNATURE: _____ DATE: _____

What Are Your Concerns?

Name of Patient: _____

Date: ____/____/____

Please review the following list and place a check mark next to any of the concerns that you may have at this time. This will help to ensure that your visits with us are comfortable and worry-free.

This document, as well as all others you complete in our office, will be kept confidential. Thank you.

I am concerned about...

- not totally understanding what will take place during surgery**
- being put to sleep**
- the equipment and instruments**
- injections**
- discomfort after surgery**
- confinement in the treatment chair**
- exposure to x-rays**
- discomfort during surgery**
- the condition of my teeth and gums**
- the time away from the job or out of school**
- the following:**

Please list any additional questions that you may have for Dr. Tawadros and his staff. It is not always easy to remember everything once you are in the treatment area. We want to make sure that we provide explanations for everything that is important to you.

1. _____
2. _____
3. _____
4. _____
5. _____
