DR. ALONA BAUER

GENERAL • COSMETIC • DENTISTRY

PATIENT INFORMATION

NAME _____ _____ _____
FIRST MIDDLE LAST

HOW DO YOU WISH TO BE ADDRESSED? _____

BIRTH DATE _____ SSN _____
MONTH DAY YEAR

MARITAL STATUS: ❍ SINGLE ❍ MARRIED ❍ DIVORCED ❍ WIDOWED

ARE ANY FAMILY MEMEBRS PATIENTS WTH US? ❍ YES ❍ NO WHO? _____

HOME ADDRESS _____ _____
STREET APT. NO.

_____ _____ _____
CITY STATE ZIP

PHONES _____ _____ _____
HOME WORK CELL

EMPLOYER _____ OCCUPATION _____

REFERRAL INFORMATION

WHO MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE? PLEASE CHECK ONE:

❍ WASHINGTONIAN ❍ MAILING ❍ PATIENT/DOCTOR _____ ❍ OTHER _____

DENTAL HISTORY

REASON FOR TODAY'S VISIT _____

PREVIOUS DENTIST _____ DATE OF LAST DENTAL EXAM _____

PLEASE READ AND INITIAL THE FOLLOWING

_____ I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

_____ I authorize the release of any information concerning my healthcare, advice and treatment to another dentist and/or insurance company to secure payment of benefits.

_____ I understand that a fee may be charged for broken appointments as well as appointments canceled with less than 48 hour notice.

_____ I understand that all professional services are charged directly to the patient and that I am responsible for payment of fees including all collection/attorney fees.

_____ _____
RESPONSIBLE PARTY SIGNATURE DATE

MEDICAL HISTORY (CONFIDENTIAL)

PHYSICIAN'S NAME _____ DATE OF LAST VISIT _____

HAVE YOU HAD ANY SERIOUS ILLNESSES OR OPERATIONS? ❍ YES ❍ NO IF YES, APPROXIMATE DATE _____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? ❍ YES ❍ NO IF YES, APPROXIMATE DATE _____

WOMEN

ARE YOU PREGNANT? ❍ YES ❍ NO HOW MANY MONTHS _____ ARE YOU NURSING? ❍ YES ❍ NO

ARE YOU CURRENTLY TAKING BIRTH CONTROL? ❍ YES ❍ NO WHICH TYPE? _____

CHECK ANY OF THE FOLLOWING YOU HAVE BEEN TREATED FOR

❍ AIDS
❍ ANAPHYLAXIS
❍ ALLERGIES
❍ ANEMIA
❍ ARTHRITIS
❍ ARTIFICIAL HEART
❍ ASTHMA
❍ ARTIFICIAL JOINTS
❍ BLOOD DISEASE
❍ BLOOD THINNERS
❍ CANCER
❍ CHEMICAL DEPENDENCY
❍ CHEMOTHERAPY
❍ CHEST PAINS
❍ CIRCULATORY PROBLEMS
❍ CONGENITAL HEART DEFECT
❍ DIABETES
❍ DIZZINESS
❍ EPILEPSY
❍ FAINTING
❍ FOOD ALLERGIES
❍ GLAUCOMA
❍ HAY FEVER
❍ HEADACHES
❍ HEART DISEASE
❍ HEART MURMUR
❍ HERPES
❍ HEPATITIS
❍ HIGH BLOOD PRESSURE
❍ JAW PAIN
❍ JAUNDICE
❍ KIDNEY DISEASE
❍ LEUKEMIA
❍ LIVER DISEASE
❍ NERVOUS DISORDERS
❍ PACEMAKER
❍ PSYCHIATRIC TREATMENT
❍ RADIATION TREATMENT
❍ RESPIRATORY PROBLEMS
❍ RHEUMATISM
❍ RHEUMATIC FEVER
❍ SHORTNESS OF BREATH
❍ SINUS PROBLEMS
❍ STROKE
❍ THYROID DISEASE
❍ TOBACCO HABIT: HOW OFTEN ____
❍ TONSILLITIS
❍ TUBERCULOSIS
❍ TUMORS
❍ ULCERS
❍ VENEREAL DISEASE
❍ OTHER: _____
❍ SENSITIVITIES OR ALLERGIES ____

MEDICATIONS

LIST MEDICATIONS YOU ARE CURRENTLY TAKING

_____

_____

ALLEGIRES

❍ ASPIRIN ❍ CODEINE ❍ LOCAL ANESTHETIC
❍ SULFA ❍ LATEX ❍ PENICILLIN
❍ OTHER _____

IS THRE ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR HEALTH THAT WE HAVE NOT COVERED ON THIS FORM?

_____

_____

DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED? IF SO, PLEASE EXPLAIN.

_____

_____

WOULD YOU LIKE TO SPEAK TO THE DOCTOR PRIVATELY ABOUT ANY PROBLEM? ❍ YES ❍ NO

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that i may have made in completing this form.

_____ _____

SIGNATURE DATE