PATIENT HISTORY & INFORMATION

Date: _____

Birth Date: _____

NAME MR. MRS. MISS: _____ Age: _____ Sex: _____ Marital Status: _____
LAST FIRST MIDDLE

ADDRESS (Home): _____ Phone: _____
STREET CITY STATE/ZIP

ADDRESS (Bus.): _____ Phone: _____
STREET CITY STATE/ZIP

Employer: _____ Occupation: _____ Social Security No.: _____

Nearest Relative in area: _____ Address: _____ Phone: _____

Who Referred you to us: _____

PERSON RESPONSIBLE FOR PAYMENT—

Name: _____ Relationship: _____ Phone: _____

Address: _____ City/State/Zip: _____

Employer: _____ Occupation: _____ Social Security No.: _____

Drivers License No.: _____

ACKNOWLEDGEMENT AND AUTHORITY

I consent to treatment as necessary or desirable to the care of the patient first named above, including but not restricted to whatever drugs, medicines, performance of operations and conduct of laboratory, x-ray, or other studies that may be used by the attending doctor, or his nurse, or qualified designate.

I unconditionally agree to be responsible for and to pay Richard C. Weber, D.D.S., for any and all of his charges which are not covered by insurance. I agree and understand that in the event I do not pay the amount due Richard C. Weber, D.D.S., and my account is placed in the hands of an attorney for collection proceedings, I will be legally responsible for all attorney fees, court costs, collection costs, consideration for assignment, litigation expenses, as well as any other incidental expenses incurred by Richard C. Weber, D.D.S., and/or his assignee(s). I further understand that a 1 1/2% finance charge (18% annually) will be added to any balance over 60 days. I further consent to venue in the Lawrence Township, Marion County, small claims court.

Signed: _____
PATIENT, PARENT OR AGENT (MUST BE 18 YEARS OR OLDER)

MEDICAL/DENTAL HISTORY—

Physician's name: _____ Address/City/State: _____ Date: _____

When did you last consult a physician? _____ Reason: _____

Have you been a patient in a hospital in the past 2 years: ☐ Yes ☐ No Reason: _____

Name of former dentist: _____ Date of last dental examination: _____

What is your immediate dental problem?: _____

Do you have, or have you had, any of the following (*Please check and describe fully under remarks*):

	YES	NO		YES	NO
1. Heart Disease	☐	☐	14. Radiation Treatment	☐	☐
2. High Blood Pressure	☐	☐	15. Liver or Kidney Disease	☐	☐
3. Blood Disease	☐	☐	16. Hepatitis, Jaundice	☐	☐
4. Rheumatic Fever	☐	☐	17. Allergies		
5. Heart Murmur	☐	☐	a. Penicillin	☐	☐
6. Diabetes	☐	☐	b. Other Antibiotics	☐	☐
7. Stroke	☐	☐	c. Local Anesthetic	☐	☐
8. Epilepsy	☐	☐	d. Others	☐	☐
9. Fainting	☐	☐	18. Asthma	☐	☐
10. Psychiatric Treatment	☐	☐	19. Respiratory Disease	☐	☐
11. Arthritis	☐	☐	21. Does your jaw "click" or hurt?	☐	☐
12. Tumor History	☐	☐	21. Are you pregnant?	☐	☐
Have you had excessive bleeding requiring treatment?				☐	☐
Have you experienced any unfavorable reaction to previous treatment?				☐	☐
Are you taking medicine, drugs or pills regularly?				☐	☐

Remarks: _____ History Update: