Thomas J. Rolfes, DDS, Christina T. Do, DDS & Michele F. McGill, DDS

Patient Information

Patient Name: ______________________________ Date:______________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ____________

Social Security #: ______________Driver's lic no. ____________ Birth Date:______________

Phone (Home): ______________ (Work): ____________ ______(Cell):______________

Email address:______________________

Address: ______________________________
Street Apartment #

____
City State Zip Code

Employment Information

Employer Name: ______________________ Occupation: ______________________

Address: ______________________________
Street City State Zip Code

Length of employment:______________

Spouse Information

Name: ______________________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ______________

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): ______________ (Work): ______________ (Cell): ______________

Spouse's Employment Information

Employer Name: ______________________ Occupation: ______________________

Address: ______________________________
Street City State Zip Code

Length of employment:______________

Dental Insurance Information

Primary

Name of Insured: ______________________ Patient's relationship: ☐ Self ☐ Spouse ☐ Child
Last First MI

ID #: ______________ Group #:______________________

Insured's Employer Name: ______________________
Employers phone

Address: ______________________________
Street City State Zip Code

Insurance Plan Name and Address: ______________________

____

Secondary

Name of Insured: ______________________ Patient's relationship: ☐ Self ☐ Spouse ☐ Child
Last First MI

ID #: ______________ Group #:______________________

Insured's Employer Name: ______________________
Employers phone

Address: ______________________________
Street City State Zip Code

Insurance Plan Name and Address: ______________________

____

Referral Information

Whom may we thank for referring you to our practice:______________________

In the event of an emergency, name of someone who lives near you that we may contact? ______________________

Relationship ______________________ hm ph # ______________ work or cell ph #______________

Health Information

Have you ever had any of the following? Please check those that apply:

☐ AIDS	___________	☐ Aneurysm	☐ Arthritis
☐ Allergies ___________	☐ Anemia	☐ Angina	☐ Artificial Joints
☐ Asthma			
☐ Heart Bypass Surgery	☐ Head Injuries	☐ Nervous Disorders	☐ Tumors
☐ Heart Attack	☐ Heart Disease	☐ Pacemaker	☐ Ulcers
☐ Blood Disease	☐ Heart Murmur	☐ **Pregnancy**	☐ Venereal Disease
☐ Cancer	☐ Hepatitis	Due date:_________	☐ Codeine Allergy
☐ Diabetes	☐ High Blood Pressure	☐ Radiation Treatment	☐ Penicillin Allergy
☐ Dizziness	☐ Jaundice	☐ Respiratory Problems	OTHER:
☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever	☐ __________________
☐ Excessive Bleeding	☐ Herpes	☐ Rheumatism	
☐ Fainting	☐ Fever Blisters	☐ Sinus Problems	☐ __________________
☐ Glaucoma	☐ Liver Disease	☐ Stomach Problems	
☐ Growths	☐ Mental Disorders	☐ Stroke	
☐ Hay Fever	☐ Mitral Valve Prolapse	☐ Tuberculosis	

- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:____
- My last complete physical was on ____
- Name of Physician: ____ Phone:___________________
- Have you ever had any trouble associated with any previous surgery or anesthetic? ☐ Yes ☐ No
  If yes, please explain:____
- Is your mouth dry? ☐ Yes ☐ No
- Do you have any type of hearing impairment? ☐ Yes ☐ No
- Do you wear contact lenses ☐ Yes ☐ No
- How much alcohol do you drink? ____
- How much do you smoke per day?____________________________ How many years have you smoked?____
- Have you taken “recreational” drugs in the past year such as cocaine, marijuana, heroin, crack, LSD? ☐ Yes ☐ No
  If so, what?______________________________ When?______________________
- Are you *allergic* to any medications ? ☐ Yes ☐ No
  If so, what: ____
- **Please list all medications you are currently taking:**

____
____
____
____

- Are there any medications you are not taking, that were prescribed to you? ______________________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. If deemed advisable, I grant permission for my physician to be contacted for details and advice. For evaluation or teaching purposes I authorize the use of my radiographs or photographs. Authorization is also given for dental treatment to be rendered by the dentist and office staff, and I will assume financial responsibility.

____ Date:_________________________________
signature of patient, parent or guardian

reviewed by: ________________