Steve M Mosby, DDS

PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form.

Patient's Name_____ **Preferred Name**_____ **DOB**_____

If minor, name of parents_____

Mailing Address_____ **City**_____ **State**_____ **Zip**_____

Home Phone_____ **Work Phone**_____ **Cell Phone**_____

Employer_____

Spouse's Name_____ **Spouse's Employer**_____

BILLING, CREDIT, AND INSURANCE INFORMATION: ☐ Not covered by dental insurance

Your Social Security number:_____ Dental Insurance Co._____ Group #_____

Member ID#_____

Covered by spouse's insurance? ☐ Yes ☐ No Spouse's insurance company_____

Group#_____ Member ID#_____ Spouse's birthday_____ Social Security#_____

Medical Health History

Do you have or have you had any of the following:

- Cancer or tumor
- Heat ailment or angina
- Heart murmur, mitral valve prolapse, heart defect
- Rheumatic fever
- Artificial joint or heart valve
- High or low blood pressure
- Pacemaker
- Tuberculosis or other lung problems
- Kidney disease
- Hepatitis or liver disease
- Alcoholism
- Blood transfusion
- Diabetes
- Neurologic condition
- Epilepsy, seizures
- Emotional Conditions
- Arthritis
- Herpes or cold sores
- AIDS/HIV positive
- Migraines/Frequent headaches
- Anemia or blood disorders
- Abnormal Bleeding after surgery
- Hayfever or sinus trouble
- Allergies or hives
- Asthma
- Do you smoke or use chewing tobacco?

Medications_____

_____

_____

Are you allergic to, or have your reacted adversely to any of the following?

- Latex materials
- Penicillin or other antibiotics
- Local anesthetics ("Novocain")
- Codeine or other narcotics
- Sulfa drugs
- Barbiturates, sedatives, or sleeping pills
- Aspirin
- Other: _____

Are you taking any of the following?

- Aspirin
- Anticoagulants(Blood Thinners)
- Antibiotics or sulfa drugs
- High blood pressure medicine
- Antidepressants or tranquilizers
- Insulin, Orinase, or other diabetes drug
- Nitroglycerin
- Cortisone or other steroids
- Osteoporosis (Bone density) medicine
- Other:_____

- Women: May be pregnant
  Expected delivery date:_____
- Taking hormones or contraceptives

Physicians Name_____

Do you have any disease/condition not listed above?_____

_____

Consent to Treat:

I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this form to administer such anesthetics, analgesics, and sedatives; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of the patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

Signed_____ **Date**_____ Consent must be signed by the patient, or parent if a minor, or caregiver if patient is physically or mentally incompetent.