

Confidential Patient Information

Date _____

PATIENT: Name _____ Home Phone _____
Last First Middle

Address _____
City State Zip

Place of Employment _____ Occupation _____

Work Address _____ Work Phone _____
City State Zip

Email address: _____ Cell Phone _____

Date of Birth _____ SS# _____ Male _____ Female _____

Height _____ ft _____ in Weight _____ # Marital Status: Single Married Divorced Widowed

Hobbies: _____

SPOUSE: Name _____

Place of Employment _____ Occupation _____
Address if different from above

Work Address _____ Work Phone _____
City State Zip

Person Responsible for Account _____
Address if different from above

A finance charge of 18% per year will be added to any account that is delinquent.

Whom may we thank for referring you to our office? _____

Has any member of your family been treated in our office previously? Yes No Relationship _____

Why did you choose Dr. Strupp as your dentist? _____

Reason for Visit: _____

DENTAL HEALTH: Please check one: Excellent Good Fair Poor

What priority do you give your teeth (10 being the highest)?

DENTAL INSURANCE:

PRIMARY Carrier Insurance Company _____

Mailing Address _____

Employee _____ SS# _____ Group # _____

SECONDARY Carrier Insurance Company _____

Mailing Address _____

Employee _____ SS# _____ Group # _____

Please complete other side

MEDICAL HEALTH: Please check one: Excellent Good Fair Poor

Physician's Name _____

Date of last complete physical: _____ Are you under a doctor's care now? _____ If yes, for what reason? _____

Please list any medications, pills or drugs you are taking: _____

Please list any vitamins or herbs you are taking: _____

Have you ever received a blood transfusion? Yes No When? _____

Are you pregnant? _____ How long? _____

Are you subject to prolonged bleeding? Yes No Do you smoke? _____ How many packs per day? _____

Soda consumption per day: _____ Candy consumption per day: _____

Are you allergic to: Penicillin Codeine Local Anesthetics Other medications – list below: _____

Please CLICK if you have or have had any of the following:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> X-Ray or Cobalt Treatment |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Chemotherapy/Radiation |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Swelling of Feet/Ankles/Hands | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Arthritis/Gout |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Congenital Heart Lesion | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis A (infectious) | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Artificial Joints/Hips | <input type="checkbox"/> Hepatitis B (serum) | <input type="checkbox"/> Alzheimer's Disease |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Parathyroid Disease | |

Have you ever had any other serious illness not check above? Yes No If yes, please describe in detail: _____

I will allow Dr. Strupp to photograph/videotape and use for educational purposes any aspect of my dental conditions or treatment procedures, and to publish any testimonials I provide. I further permit him to discuss my conditions with my physician and to request medical information from him.

Patient's Signature _____

MEDICAL UPDATES:

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

Date	Exceptions	Patient's Signature	Reviewed By
_____	_____ None <input type="checkbox"/>	_____	_____
_____	_____ None <input type="checkbox"/>	_____	_____
_____	_____ None <input type="checkbox"/>	_____	_____