PATIENT INFORMATION

Dr. Earl P. Duffy Jr.,D.D.S., Dr. Brannon J. Gunnell D.D.S., Dr. Kyle P. Duffy, D.M.D.

PATIENTS NAME_____ _____ **Today's date**_____
(LAST) (FIRST)

Address_____ **City** _____ **State** ____ **Zip Code** _____
***Mailing Address**_____ **City**_____ **State** ____ **Zip Code**_____
(If different from physical address) E-Mail address_____

Home Phone #_____**Work #**_____**Cell Phone#** _____
Date of Birth_____ **Age** _____ **Social Security#**_____
Occupation _____**Employer**_____ **Phone#**_____
Employers Address _____ **City**_____ **State**____ **Zip Code**_____

Spouses Name_____ **Spouses S.S.#**_____**D.O.B.**_____
Spouses Occupation_____ **Employer**_____ **Phone #**_____

Person to contact in case of emergency_____ **Relationship**_____
Home #_____ **Work #**_____**Cell #**_____

New Patients…Who can we thank for referring you to us?_____
Are you interested in WHITENING your teeth? Yes No

DENTAL INSURANCE INFORMATION

Name of Insured _____**Relationship to patient**_____
Birth Date _____ **Soc. Sec.#** _____ **Employer**_____
Insurance Company_____**Group#**_____**I.D#**_____
Claims Address_____ **City**_____ **State**_____ **Zip**_____

PLEASE PRESENT INSURANCE CARD AT FRONT DESK

HEALTH HISTORY

List your current Physician(s)

1. _____ **Phone #**_____
2. _____ **Phone #**_____

Please list any medications you are ALLERGIC to:

_____ _____ _____ _____

Please list all medications you are NOW TAKING (or provide a list we can copy):

_____ _____ _____ _____

_____ _____ _____ *Continue to back side of form*

(1) Are you having pain or discomfort at this time? Yes No
(2) Do you feel nervous about having dental treatment? Yes No
(3) Are you aware of any changes in your general health in the last year? Yes No
(4) Have you been hospitalized for illness or surgery in the past two years? Yes No
(5) Have you been under a medical doctor's care during the past 2 years? Yes No
(6) Have you ever had excessive bleeding that required special treatment? Yes No
(7) Do you smoke or use smokeless tabacco? Yes No
How much?_____ How long ?_____

Circle all of the following you have had (or) currently have:

-HEART TROUBLE
-HEART DISEASE OR ATTACK
-ANGINA
-EMPHYSEMA
-HEPATITIS
-TUBERCULOSIS
-CONGENITAL HEART LESIONS
-ARTIFICIAL HEART VALVE
-SCARLET FEVER
-HEART SURGERY
-STROKE
-ULCERS
-BLOOD THINNER
-HEART MURMUR
-LATEX ALLERGY
-DRUG/ALCOHOL ADDICTION

-ARTIFICIAL JOINT
-KIDNEY / BLADDER TROUBLE
-THYROID DISEASE
-HIGH BLOOD PRESSURE
-LOW BLOOD PRESSURE
-ASTHMA
-HAY FEVER
-SINUS TROUBLE
-ALLERGIES OR HIVES
-DIABETES
-PACEMAKER
-SHORTNESS OF BREATH
-EPILEPSY OR SEIZURES
-CANCER
-FREQUENT HEADACHES
-FAINTING / DIZZY SPELLS
-UNINTENTIONAL WEIGHT GAIN/LOSS-

-RADIATION TREATMENT
-CHEMOTHERAPY
-ARTHRITIS / RHEUMATISM
-GLAUCOMA
-PERSISTENT COUGH
-RHEUMATIC FEVER
-ANEMIA
-LIVER DISEASE
-JAUNDICE
-AIDS
-BLOOD TRANSFUSION
- SICKLE CELL DISEASE
-HEMOPHILIA
-VENEREAL DISEASE
-TUMORS
-NERVOUSNESS
-PSYCHIATRIC CARE
-Taken PHEN-FEN
-MITROVALVE PROLAPSE

Women Only:
Are you pregnant? Yes No Taking birth control pills? Yes No
-Do you anticipate becoming pregnant? Yes No

Do you have any medical conditions/diseases not listed above that we should know about?
Yes No Explain_____

**I understand that my dental insurance (if any) may pay less than the actual bill for services. I agree to pay all services rendered on my behalf and on behalf of my dependants, at the time they are COMPLETED. If balances are not paid I agree to pay all collection costs and attorney fees incurred to effect collection on this account.

_____ _____ _____
Patient Signature Parent/Guardian Signature (If minor) Date