

PATIENT DEMOGRAPHICS - PLEASE PRINT:

PATIENT'S NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ **ZIP CODE:** _____

HOME #: _____ **WORK #:** _____

CELL #: _____ **EMAIL:** _____

DATE OF BIRTH: _____ **GENDER:** _____ **M** _____ **F** _____

SOCIAL SECURITY #: _____

OCCUPATION: _____

MARITAL STATUS: _____

WERE YOU REFERRED BY A PHYSICIAN: _____ **YES** _____ **NO** _____

NAME OF REFERRING PHYSICIAN: _____

PRIMARY PHYSICIAN IF DIFFERENT: _____

PRIMARY INSURANCE: _____

INSURANCE ID #: _____

GROUP ID #: _____

SECONDARY INSURANCE ID #: _____

SECONDARY GROUP ID #: _____

POLICY HOLDER'S INFORMATION:

NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY #: _____

RELATIONSHIP TO PATIENT: _____

NAME: _____

DOB: _____

PAGE: _____

DATE _____

HAVE YOU EVER BEEN DIAGNOSED OR TREATED FOR:
IF YES PLEASE SPECIFY

HEART DISEASE	YES	NO
HIGH BLOOD PRESSURE	YES	NO
LUNG DISEASE/ASTHMA	YES	NO
CANCER	YES	NO
DIABETES	YES	NO
THYROID DISEASE	YES	NO
GASTROINTESTINAL DISEASE	YES	NO
NEUROLOGICAL DISEASE OR STROKE	YES	NO
PSYCHIATRIC DISORDER	YES	NO
INFECTIOUS DISEASE (Hepatitis, Tuberculosis, Lyme, HIV)	YES	NO
HISTORY OF KELOIDS, SCARS, EXCESSIVE BLEEDING	YES	NO
SKIN DISORDERS	YES	NO
OTHER MEDICAL CONDITIONS	YES	NO

DO YOU HAVE A HISTORY OF SKIN CANCER? YES NO

HAVE YOU EVER HAD A BLISTERING SUN BURN? YES NO

IS THERE A FAMILY HISTORY OF SKIN CANCER? YES NO

LIST FAMILY MEMBER/TYPE OF SKIN CANCER: _____

LIST ALL MEDICATIONS YOU CURRENTLY TAKE: _____

DO YOU TAKE ASPIRIN DAILY? YES NO

DO YOU SMOKE? YES FREQUENCY NO

DO YOU DRINK ALCOHOL? YES FREQUENCY NO

DO YOU TAKE AN ANTIBIOTIC BEFORE DENTAL WORK? YES NO

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO

PLEASE SPECIFY: _____

ARE YOU ALLERGIC TO ANESTHESIA?
(LIDOCAINE, NOVOCAINE, OTHER)? YES NO

HAVE YOU EVER REACTED TO EPINEPHRINE? YES NO

ARE YOU PREGNANT OR NURSING? _____

HAVE YOU EVER HAD: (PLEASE SPECIFY)
MAJOR SURGERY _____

COSMETIC SURGERY _____

PATIENT'S SIGNATURE

MD'S SIGNATURE