Clive B. Rayner DMD and Associates
PATIENT INFORMATION RECORD

Date_____

Mr. Mrs. Miss Ms. Dr. (please circle)

Patient's Name_____Social Security# _____ - _____ -_____

Patient is: Single____ Married____ Widowed____ Divorced____ Separated____

Patient'sAddress_____
Street Apt. # City Zip

Home Phone ( ) _____Cell Phone ( ) _____ Business Phone ( )_____

Patient's Age _____ Date of Birth _____ Male _____ Female _____

Patient's Employer _____ Occupation _____

Patient Email address _____

Emergency Contact: _____ Phone _____

Spouse's Name_____ Date of Birth _____

Spouse's Occupation _____Employer _____Business Phone ( ) _____

If Patient is a Minor or Dependent:

Parents are married or divorced **(please circle one)**

Mother/Guardian Name_____ **Father/Guardian Name**_____

SS# _____- ____- _____ DOB_____ SS# _____ -____ - _____DOB_____

Mother's Occupation Employer & Contact Number: **Father's Occupation Employer & Business Number**:

_____ _____

Dental Insurance Company_____

Policy Holder _____ Policy Holder's SS# _____ - ____ - _____ Policy Group# _____

Medical Insurance Company _____

Policy Holder _____ Policy Holder SS# _____-_____-_____ Policy Group #_____

Name of Patient's Dentist _____

Name of Patient's Primary Care Physician_____ Phone Number_____

Name of Patient's other MD's_____ Phone Number _____

_____ Phone Number _____

Who Referred the patient to our Office?_____

Have you or any other family member been a patient in our office before? _____

Who was seen? _____ When?_____

I understand that it is customary to make payment at the time that services are rendered.

_____

Responsible Party Signature Date

Staff _____ Dr. _____

Over please ->

MEDICAL HISTORY

____Have you been seen by a physician in the past 5 years for any reason?_____

____Reason: _____

____List types and dates of ***all*** previous surgeries or operations: _____

_____

_____

____Please list ***all*** medications, herbs and supplements you are currently taking: _____

_____

_____

____Have you ever had general anesthesia? Yes ____ No ____ Any Complications? _____

_____

____Do you have allergies or are you sensitive to drugs such as penicillin, novocaine, aspirin or codeine?_____

_____

____Do you smoke cigarettes? Yes ____No ____ If yes, how many packs per day? _____ packs

____Do you use any other tobacco products? Yes ____ No ____ If yes, what _____ how often? _____

____Do you drink alcohol? Yes_____ No_____How many drinks per day? _____

____Do you bleed excessively after a cut, wound or surgery?_____

____ Do you presently have a cold, cough or sinus trouble?_____

____ Have you ever taken weight loss pills, such as "Phen-Fen" ___Yes ___ No When?_____

____Have you ever taken any medications, like **"Fosamax,"** for osteoporosis _____Yes _____No

____Do you have sleep apnea _____ Yes _____ No Do you use a **CPAP** breathing machine at night? _____Yes _____ No

____Do you wear contact lenses? Yes____ No____ If female, is there a possibility you are pregnant? Yes_____ No_____

____Have you ever had any of the following illnesses?

YES	NO		YES	NO		YES	NO	
___	___	**Rheumatic Fever**	___	___	**Hearing Problems**	___	___	**TB**
___	___	**Heart Problems**	___	___	**Diabetes**	___	___	**Heart Murmur**
___	___	**High or Low Blood Pressure**	___	___	**Asthma**	___	___	**Pacemaker**
___	___	**Stroke**	___	___	**Emphysema or Breathing Problems**	___	___	**Glaucoma**
___	___	**Vision Problems**	___	___	**Epilepsy or Seizure Disorder**	___	___	**Radiation**
___	___	**Hepatitis or Liver Disease**	___	___	**Anemia or Blood Disease**	___	___	**Chest Pain/Angina**
___	___	**Kidney Disease**	___	___	**Thyroid Disease**	___	___	**Nervous breakdown or**
___	___	**Fainting or Dizziness**	___	___	**Recreational Drug Use or Addiction**			**Psychiatric Treatment**
___	___	**HIV Infection**	___	___	**TMJ (Jaw Joint) Problem**	___	___	**Osteoporosis**

____Other relevant medical problems or information: _____

_____

_____

____Is there anything you wish to speak to the doctor about privately? _____Yes _____ No

____What is your reason for needing to see an oral surgeon? _____

To the best of my knowledge, this information is complete and correct; I can read & write English.

_____

Responsible Party Signature **Date**

Staff _____ Dr. _____