

**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's Address _____

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. _____

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

___ Rheumatic Fever
___ Heart Problems
___ High or Low Blood Pressure
___ Stroke
___ Vision Problems
___ Hepatitis or Liver Disease
___ Kidney Disease
___ Fainting or Dizziness
___ HIV Infection

YES NO

___ Hearing Problems
___ Diabetes
___ Asthma
___ Emphysema or Breathing Problems
___ Epilepsy or Seizure Disorder
___ Anemia or Blood Disease
___ Thyroid Disease
___ Recreational Drug Use or Addiction
___ TMJ (Jaw Joint) Problem

YES NO

___ TB
___ Heart Murmur
___ Pacemaker
___ Glaucoma
___ Radiation
___ Chest Pain/Angina
___ Nervous breakdown or
___ Psychiatric Treatment
___ 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. ___