MEDICAL HISTORY

Family physician name & city ______________________

Please describe any medical conditions for which you are being treated ______

____

Please list any medications you are currently taking ______________________

____

Please list any drug allergies or reactions ______________________

Please list any premedication needed ______________________

Please check the appropriate YES or NO box on each question.

	YES	NO
Recent physical exam	☐	☐
Cleft lip/palate	☐	☐
Heart problems	☐	☐
Diabetes	☐	☐
Epilepsy	☐	☐
Hepatitis	☐	☐
Excessive bleeding or clotting problems	☐	☐
Rheumatic fever	☐	☐
Scarlet fever	☐	☐
Tuberculosis	☐	☐
Venereal disease	☐	☐
Blood-borne disorders (i.e.Hep.B or C,HIV,Venereal Disease,etc)	☐	☐
Blood transfusion	☐	☐
Heart murmur	☐	☐
Glaucoma	☐	☐
Pregnant	☐	☐
Other ______________	☐	☐

Comments: ______________________

____

TREATMENT INFORMATION

Diagnosis: ______________________

____

____

____

Treatment Plan: ______________________

____

PATIENT PROFILE CARD

PATIENT INFORMATION

Patient Name ______________________________

Birth date ______________ Age _______ Male _____ Female ____

Address ______________________________

City, State, Zip ______________________Home Phone#__________

Family Dentist ____________________Referred by__________________

Patient Relationship: Self ___Child___ Spouse ___ Other ______________

BILLING INFORMATION

Primary Responsible Name ______________________________

Address _______________________City, State, Zip______________

Phone #: Hm ____________ Wk______________ Cell______________

Employer ________________ Dental Insurance Co. ________________

Group# __________ SS#____________________ Birth date __________

Secondary Responsible Name ______________________________

Address________________________City,State,Zip________________

Phone #: Hm ____________ Wk _______________ Cell ____________

Employer ____________________Dental Insurance Co. ______________

Group # ________ SS# ____________________ Birth date ___________

SIGNATURE______________________________**DATE**__________

I agree to allow Dr. David Weaver to check my credit references prior to arranging financing.

SIGNATURE DATE