Walter D. Fain D.D.S.

Welcome to our office. We will do our best to make your appointments as convenient and pleasant as possible. If at any time you have any questions regarding your treatment, your appointments, or your fee, please feel free to ask.

Mrs.
Mr. Miss
Name Dr. Ms. _____
Please Print Last First Middle Initial Name you prefer to be called

Residence Address _____ Phone _____

City _____ State _____ Zip _____ Age _____

Cellular Phone _____Soc. Sec. # _____ Birthdate _____

Employer _____ Work Phone _____

Nature of dental problem _____

Whom may we thank for referring you to us _____ Spouse name _____

Name of person responsible for account _____ If address is different from above, please include

Street Address _____ Home Phone _____

City _____ State _____ Zip _____ Work Phone _____

Do you have dental insurance? _____ If so, please fill out the white form entitled Dental Insurance Information.

Medical History

Physician's name _____

Have you been under a physician's care during the past two years? Yes _____ No _____

If so, what? _____ Do you use tobacco? Yes _____ No _____

Are you taking any drugs or medicines? If so, List_____ _____

Women – Are you pregnant? _____ Nursing? _____ Are you taking oral contraceptives? _____

Are you allergic to Aspirin _____ Codeine _____ Penicillin _____ Local Anesthetics_____

Other drugs, medicines, metals, latex, or other materials _____

If you have had any of the following, mark yes. If not, mark no.

	Yes	No		Yes	No		Yes	No
Heart Problems	___	___	Epilepsy	___	___	Stomach Ulcer	___	___
Heart Pacemaker	___	___	Fainting	___	___	Nervous Problems	___	___
High Blood Pressure	___	___	Asthma	___	___	Tuberculosis	___	___
Heart Attack or Stroke	___	___	Hepatitis	___	___	Diabetes	___	___
Angina/Chest Pain	___	___	Kidney Disease	___	___	Sinus Problems	___	___
Frequent Headaches	___	___	Aids, HIV +	___	___	Liver Disease	___	___
Excessive Bleeding	___	___	Arthritis	___	___	Respiratory Problem	___	___
Circulatory Problems	___	___	Leukemia	___	___	Thyroid Problem	___	___
Artificial Heart Valve	___	___	Artificial Joint	___	___	Chemo/Radiation Therapy	___	___
Mitral Valve Prolapse	___	___	Heart Murmur	___	___	Rheumatic Fever	___	___

Date _____ Patient's Signature _____
(Parent's Signature if Minor)