Pullen Comprehensive and Cosmetic Dentistry

2353 Whitesburg Drive
Huntsville, Alabama 35801
Phone 256/533-3735

Patient Information

Name _____ (LAST / FIRST / MIDDLE) Phone: (____) _____ Work Phone: (____) _____

Address _____ City _____ State _____ Zip _____

Patient Sex: M F Marital Status: S M D SEP W

Social Security Number ___ – ___ – ___ Date of Birth: ___ (MONTH) – ___ (DAY) – ___ (YEAR)

Physicians Name & Phone #: _____ Former Dentist: _____

Is Patient a full time student? Y or N Name of School: _____

Whom may we thank for referring you to us? _____

Person Responsible for Bill

Name _____ Relationship to Patient: Self Spouse Father Mother

Employer _____ Occupation: _____

Employer's Address _____ Phone: (____) _____

Social Security Number ___ – ___ – ___ Date of Birth: ___ (MONTH) – ___ (DAY) – ___ (YEAR)

Spouse's Name _____ Relationship to Patient: Self Spouse Father Mother

Employer _____ Occupation: _____

Employer's Address _____ Phone: (____) _____

Social Security Number ___ – ___ – ___ Date of Birth: ___ (MONTH) – ___ (DAY) – ___ (YEAR)

I/We agree to be responsible for full payment of the charges for dental services performed on the above patients, regardless of assignment of any insurance benefits. Should it be necessary to take action to collect any amount owed under this agreement, I/we agree to be responsible for all costs of collection, including, but not limited to, a reasonable attorney's fee and court. cost.

Signature _____ Date: _____

Relationship _____

For Patients with Dental Insurance

Primary Insurance _____ Name of Employee _____

Employer _____ Contract # _____

Address / City / State / Zip _____ Telephone (____) _____

Date of Birth of Policyholder ___ (MONTH) – ___ (DAY) – ___ (YEAR) Occupation _____

Secondary Insurance _____ Name of Employee _____

Employer _____ Contract # _____

Address / City / State / Zip _____ Telephone (____) _____

Date of Birth of Policyholder ___ (MONTH) – ___ (DAY) – ___ (YEAR) Occupation _____

OVER

MEDICAL HISTORY

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be _____ additional questions concerning your health.

1. Are you in good health? ..... Yes No
2. Has there been any change in your general health within the past year? ..... Yes No
3. My last physical examination was on _____
4. Are you now under the care of a physician? ..... Yes No
   If so, what is the condition being treated? _____
5. The name and address of my physician(s) is _____
   _____
   a. The name of my former Dentists _____
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? ..... Yes No
   If so, what was the illness or problem? _____
7. Are you taking any medicine(s) including non-prescription medicine? ..... Yes No
   If so, what medicine(s) are you taking? _____
8. Do you have or have you had any of the following diseases or problems
   a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease ..... Yes No
   b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke, inborn heart defects, pace maker) ..... Yes No
   c. Sinus trouble, asthma, hayfever ..... Yes No
   d. Fainting, spells or seizures ..... Yes No
   e. Persistent diarrhea or recent weight loss ..... Yes No
   f. Diabetes ..... Yes No
   g. Hepatitis, jaundice or liver disease ..... Yes No
   h. AIDS or HIV infections ..... Yes No
   i. Thyroid problems ..... Yes No
   j. Respiratory problems, emphysema, bronchitis, etc. ..... Yes No
   k. Arthritis or painful swollen joints ..... Yes No
   l. Stomach ulcer or hyperacidity ..... Yes No
   m. Kidney trouble ..... Yes No
   n. Tuberculosis ..... Yes No
   o. Persistent cough or cough that produces blood ..... Yes No
   p. Persistent swollen glands in neck ..... Yes No
   q. Low blood pressure ..... Yes No
   r. Sexually transmitted disease ..... Yes No
   s. Epilepsy or other neurological disease ..... Yes No
   t. Cancer ..... Yes No
   u. Problems of the immune system ..... Yes No
9. Have you had abnormal bleeding? ..... Yes No
   a. Have you ever required a blood transfusion? ..... Yes No
10. Do you have any blood disorder such as anemia? ..... Yes No
11. Have you ever had any treatment for a tumor or growth? ..... Yes No
12. Are you allergic or have you had a reaction to:
   a. Local anesthetics ..... Yes No
   b. Penicillin or other antibiotics ..... Yes No
   c. Sulfa drugs ..... Yes No
   d. Barbiturates, sedatives, or sleeping pills ..... Yes No
   e. Aspirin ..... Yes No
   f. Codeine or other narcotics ..... Yes No
   g. Other _____ Yes No
13. Have you had any serious trouble associated with any previous dental treatment? ..... Yes No
   If so, explain _____
   _____
14. Do you have a disease, condition, or problem not listed above that you think I should know about? ..... Yes No
   If so, explain _____
   _____

Women

15. Are you pregnant? ..... Yes No
16. Are you nursing? ..... Yes No
17. Are you taking birth control pills? ..... Yes No

Chief Dental Complaint _____
_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____
Signature of Patient