CONFIDENTIAL PERSONAL AND MEDICAL HISTORY

(Please complete every blank)

Name – Mr., Mrs., Ms. ____ Soc. Sec #______-_____-_______ Sex__________________

Street____ Apt. #__________ City_____________________ Zip____________

Age__________ Birth Date________________ Home Phone____________________________ Cell Phone _____________________________

Occupation _________________________ Employer __________________________________Bus phone______________________________

Regular Dentist______________________________________Who referred you to this office?____

Physician_____________________________________ Address____

Spouses' Name_________________________________Employer____City____________________

Spouses' Soc Sec. #_______-______-_________Work phone________________________________Birth date_____________________________

Responsible Party____Soc. Sec #_______-______-___________

Name of Dental Insurance Co.________________________________ID #____________________________Group #_______________________

Secondary Dental Insurance Co._______________________________ID #____________________________Group #_____________________

Is the problem you are seeking treatment for the result of an ACCIDENT: Yes No

If so, is medical, auto, or other third party insurance available Yes No Other Insurance__________________________________

Note: We will assist you in providing documentation of fees for services provided. You are responsible for all charges and for obtaining reimbursement from your insurance company. If the insurance does not pay within ninety days, you will be required to pay the balance in full.

Circle any of the following which you have had or have at the present:

Heart Condition	**Anemia or Hemophilia**	**Skin Rashes or Hives**	**Thyroid Disease**	**Radiation Therapy (X-Ray, Cobalt)**
Heart Attack or Stroke	**Bruise Easily**	**Kidney Trouble**	**Cortisone Medicine**	**Chemotherapy(Cancer, Leukemia)**
Heart Murmur	**Shortness of Breath**	**Diabetes**	**Glaucoma**	**AIDA, ARC**
Chest Pains (Angina)	**Swelling of Ankles**	**Sickle Cell Disease**	**Arthritis or Rheumatism**	**HIV Positive, High Risk**
Heart Surgery	**Artificial Joint**	**Liver Disease**	**Pain in Jaw Joints**	**Venereal Disease**
Artificial Heart Valve	**Lung Disease**	**Hepatitis A (infectious)**	**Fainting or Dizzy Spells**	**Genital Herpes**
Heart Pacemaker	**Tuberculosis (T.B.)**	**Hepatitis B (serum)**	**Alcoholism**	**Cold Sores**
High Blood Pressure	**Asthma or Hay Fever**	**Yellow Jaundice**	**Drug Use/Addiction**	**Epilepsy or Seizures**
Rheumatic Fever	**Sinus Trouble**	**Blood Transfusion**	**Cancer of Tumor**	**Psychiatric Treatment**

Do you have any diseases, conditions or problems not listed above?....Yes....No

NOTES

Are you presently taking any medications or drugs?...................................Yes....No
ARE YOU ALLERGIC TO ANY MEDICINE OR DRUG?..................Yes....No
Are you allergic to Latex rubber?...Yes....No
Are you under the care of a physician..Yes....No
Have you ever been hospitalized or had surgery..Yes....No
Have you ever had a reaction to local anesthetic(Novocaine)?...............Yes....No
Have you ever had prolonged bleeding?...Yes....No
Have you ever had complications following dental treatment?..............Yes....No
Have you ever had injury or trauma to your face?..Yes....No

WOMEN: ARE YOU PREGNANT NOW?............Yes.....No Due Date:______________ Are you nursing?...........Yes.....No
Are you practicing birth control?...............Yes....No Do you anticipate becoming pregnant?.........................Yes.....No

To the best of my knowledge, all of the preceding answers are true and correct. I ACCEPT FULL RESPONSIBILITY FOR ALL TREATMENT PERFORMED BY DR. BRANDYS. I understand payment is expected at the time services are rendered. I understand that insurance coverage is a contractual arrangement between myself and my insurance company. I understand that should my account become past due, I will be responsible for all fees, interest charges, late charges, and all the costs of collection including, but not limited to, attorney's fees and court costs. My signature on this form authorizes the release of any information relating to claims filed on my behalf and also authorizes payment sent directly to Dr. Robert F. Brandys.

Date: ________________________ ____

Signature of Patient, Parent or Guardian, or Responsible Party