PATIENT: First Name _______________M.I. ____ Last Name _________________________Date ____________

Address__________________________________City_____________________ State ____ Zip ______________

Primary Phone ______________________ Business Phone _____________________ Ext. ________

Social Sec # ______________ Email___________________________________ Birth Date ______________

Age ___ Male ___ Female ___ Married ___ Single ___ Dependent ___

Employer ________________________________ Phone ______________________

Address ___________________________________ City __________________ State _____ Zip ____________

. . . .

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT? Self ___ Spouse ___ Father ___Mother ___Other __________

If self, please skip to next section.

Name ________________________________ Social Sec # __________ DOB___________ Phone _____________

Address ______________________________________ City _______________ State ________ Zip ____________

Employer _____________________________________Address ____

City _______________ State _________ Zip _____________

. . . .

PHARMACY INFORMATION:

Pharmacy Name ___________________________________ Phone______________________________________

Address____

. . . .

In case of emergency, call: Name ___________________________ Phone# ____________________________

Address _______________________________________ City _______________ State _______ Zip _____________

Nearest Relative not living with you. Name _______________________________ Phone# ___________________

Address ___________________________________ City __________________State _________ Zip_____________

. . . .

What is your dental problem?

____

____

Referred by____________________Regular Dentist _____________________ Family Physician _________________

Escort Name _______________________________________ Relationship ________________________

Have you had anything to eat or drink in the last six hours? No ___ Yes ___ If yes, what?______________________

. . . .

AUTHORIZATION AND ASSIGNMENT

TO MY KNOWLEDGE THE ABOVE INFORMATION IS CORRECT. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES MADE BY THE ABOVE NAMED PATIENT.

DATE _______________ SIGNED ____

I HEREBY AUTHORIZE DONAL R. WOODWARD, D.D.S TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO DONAL R. WOODWARD, D.D.S. ALL PAYMENTS FOR DENTAL / MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS.

DATE_______________ SIGNED ____

WOODWARD
ORAL SURGERY

YES NO

1. ARE YOU BEING TREATED BY A PHYSICIAN NOW?..

   IF YES, FOR WHAT REASON?____

2. ARE YOU TAKING ANY MEDICINE AT THE PRESENT TIME?...

   IF YES, PLEASE LIST____

   ____

   ____

3. ARE YOU ALLERGIC TO ANY MEDICATIONS?..

   IF YES, PLEASE LIST ____

   ____

4. DO YOU HAVE A COLD, SORE THROAT OR UPPER RESPIRATORY ILLNESS NOW?..
5. HAVE YOU EVER HAD EXCESSIVE BLEEDING FROM WOUNDS OR EXTRACTIONS?..

   IF YES, PLEASE EXPLAIN____

6. DO YOU GET SHORT OF BREATH OR HAVE CHEST PAINS?...
7. HAVE YOU GAINED OR LOST MUCH WEIGHT RECENTLY?...
8. HAVE YOU BEEN TREATED FOR OSTEOPOROSIS?...
9. HAVE YOU EVER HAD RADIATION TREATMENT FOR ANY HEALTH PROBLEM?...
10. HAVE YOU EVER HAD A GENERAL ANESTHETIC FOR SURGERY IN THE HOSPITAL?...................................
11. HAVE YOU EVER HAD A GENERAL ANESTHETIC FOR ORAL SURGERY OR TOOTH REMOVAL?........................
12. HAVE YOU EVER HAD AN UNUSUAL REACTION TO NOVOCAINE OR ANY OTHER ANESTHETIC?......................
13. (WOMEN) ARE YOU PREGNANT AT THIS TIME?..
14. DO YOU USE: TOBACCO ALCOHOL MARIJUANA...
15. HAVE YOU EVER HAD:

	YES	NO		YES	NO
HEART DISEASE.......................			HEPATITIS OR HIV.........................		
RHEUMATIC FEVER..................			KIDNEY DISEASE..........................		
HEART MURMUR.....................			DIABETES.....................................		
HIGH BLOOD PRESSURE...........			ANEMIA...		
LUNG DISEASE.......................			STROKE...		
ASTHMA................................			SEIZURES OR EPILEPSY..................		

16. LIST ANY HEALTH PROBLEM NOT COVERED ABOVE____

    ____

17. HAVE YOU EVER BEEN HOSPITALIZED?________________IF ANSWER IS YES, PLEASE LIST APPROXIMATE DATE(S) AND REASON(S) FOR HOSPITALIZATION____

    ____

18. APPROXIMATE DATE OF LAST MEDICAL APPOINTMENT____
19. WHAT IS YOUR HEIGHT? __________________ WEIGHT?__________________

DATE:__________________SIGNED:____