Joy Gabriel, DMD, Inc. - PATIENT INFORMATION FORM Name ____________________________

Demographic information → **Write "N/C" if NO CHANGES in demographic information from last form completed**

Address ____________________________ *City* ________________ *Zip* ________

Home Ph (___) ___-____ *Wk Ph* (___) ___-____ *Ext* _____ *Cell* (___) ___-____ *email:* ________________

Birth Date ___/___/___ *Sex: M F* *SSN* ________ *Full time student? Y N* *School:* ____________

Height ____ *Weight* ____ *Driver's License #* ____________ *Employer* ________________

Employer's Address ________________________ *Phone* ____________ *How Long?* ________

Occupation ______________ *Spouse/Parent* *(if Patient is a minor)* ________________

Spouse/Parent Employer ________________________________ *Phone* ____________

1st Dental Insurance Co. ________________________________ *Phone* ____________

Subscriber's Name ____________________ *Birth Date* ___/___/___ *SSN* ____________
2nd Dental Insurance Co. ________________________________ *Phone* ____________

Subscriber's Name ____________________ *Birth Date* ___/___/___ *SSN* ____________
Nearest relative not living with you ________________________ *Phone* ____________

Your physician ________________________________ *Phone* ____________

Previous dentist ____________________ *City* ____________ *Phone* ____________

Referred by ______________ *How may we help you today?* ________________________
Are you interested in having whiter teeth? ______________

Health History ***(Please Circle One)***

1. Have you been treated by a physician(M.D.) in the past 2 years? **Reason**:............ Yes No Don't Know
2. Have you ever had surgery on the heart, blood vessels, lungs or kidneys? .... Yes No Don't Know
3. Have you taken any drugs or medicine regularly during the past 6 months? .... Yes No Don't Know

   My Medications are: ____

4. Have you taken **Phen-Phen?** .... Yes No Don't Know
5. Do you have a **LATEX** allergy? .... Yes No Don't Know
6. Do you use non-prescription "Street" drugs? (Cocaine, Marijuana, Amphetamines, Etc.) .... Yes No Don't Know
7. Have you ever had an **allergic reaction** to anesthesia,medication,drugs or metals (i.e. jewelry)? Yes No Don't Know

   Allergies: ____

8. Have you ever had a problem with a general anesthesia (completely asleep)? .... Yes No Don't Know
9. Have you ever had a problem with a local anesthesia (numbing an area)? .... Yes No Don't Know
10. Have you ever had excessive bleeding requiring special treatment? .... Yes No Don't Know
11. Have you ever had radiation treatment for cancer? .... Yes No Don't Know
12. Do you, or have you ever had pain/clicking of the jaw joints? .... Yes No Don't Know
13. Have you ever taken **antibiotics** for any **heart valve disease/defect?** Antibiotic: ________ Yes No Don't Know
14. Amount of alcohol intake? Daily ____________ Weekly ____________ Occasionally ____________
15. Smoking (packs per day)? ____________________
16. **Women:** Is there a possibility that you are **pregnant?** _____ How many mos? _____ Are you nursing? _____

Continue to the back page

Please circle, "yes" or "no" to the following health conditions:

High blood pressure: ___________ Yes / No	Current Anemia: ______________ Yes / No	Chronic Viral Infections: ________ Yes / No
MI/Heart attack: _______________ Yes / No	Ulcers: ________________________ Yes / No	A.I.D.S.: ______________________ Yes / No
Congestive heart failure: _______ Yes / No	Tested H.I.V. positive: __________ Yes / No	Cancer: _______________________ Yes / No
Irregular heart beat: _ Yes / No	Colitis: _______________________ Yes / No	Arthritis: ______________________ Yes / No
Ankle Edema: __________________ Yes / No	Infectious Hepatitis: ____________ Yes / No	Chronic Sinus: __________________ Yes / No
Chest pain/Angina: _____________ Yes / No	Serum Hepatitis: ________________ Yes / No	Chronic hay fever: _____________ Yes / No
Poor circulation: _______________ Yes / No	Jaundice: ______________________ Yes / No	Psychiatric Treatment: __________ Yes / No
Rheumatic fever: _______________ Yes / No	Kidney Infection: ______________ Yes / No	Epilepsy/Seizures/Blackouts: ____ Yes / No
Scarlet fever: __________________ Yes / No	Kidney failure: _________________ Yes / No	Dizziness: ______________________ Yes / No
Asthma: _______________________ Yes / No	Bladder infection: ______________ Yes / No	Stroke: _________________________ Yes / No
Mitral valve prolapse: __________ Yes / No	Prostate infection: _____________ Yes / No	
Bronchitis: ____________________ Yes / No	Neck/spine Problems: ___________ Yes / No	
Pneumonia: ____________________ Yes / No	Artificial Joints: _______________ Yes / No	
Emphysema: ___________________ Yes / No	Syphilis: _______________________ Yes / No	
Shortness of breath: ____________ Yes / No	Herpes: ________________________ Yes / No	
Tuberculosis: __________________ Yes / No	Gonorrhea: _____________________ Yes / No	
Diabetes: ______________________ Yes / No	Frequent headaches: ____________ Yes / No	

Other serious illnesses or major surgeries: ____

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To the best of my knowledge the above information is correct and current. I/We the undersigned herewith give consent to Dr. Joy Gabriel, and/ or associates and assistants of their choice to secure X-rays and to perform whatever diagnostic procedures that are necessary for the determination of appropriate treatment. The policy of this office limits accounts to 60 days. After 60 days a service charge of 1.5% per month (18% A.P.R.) Will be added to each account.

Patient/Parent or Guardian Signature _______________________________ Date ________________

(FOR OFFICE USE ONLY)

REVIEW : Date __________ Initials _______ Date __________ Initials _______ Date ________ Initials _________

Blood Pressure: Date __________ BP ___________ Date __________ BP ____________ Date ________ BP ___________

NOTES: ____

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