CLARK

oral & facial surgery

Paul Clark, DMD, MD

Patient Information

Name:____ Birthdate: ______________

Address:____________________ City: ____________State: ______Zip: __________

Home phone:______________ Work phone:______________ Email: ______________

Sex: ❑ M ❑ F Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Partnership ❑ Widowed

Employer or School: ______________________________Phone: ______________

Address:____________________ City: ____________State: ______Zip: __________

Spouse, partner or parent name:____

Person to contact in case of an emergency: ______________________Phone: ______________

How did you learn about our practice or whom may we thank for referring you? ______________

Who is responsible for your account and payment? (if different from patient): ______________

Address:____________________ City: ____________State: ______Zip: __________

Phone: ______________________Birthdate:______________

Pharmacy

Preferred pharmacy name:______________________ Zip Code of pharmacy:______________

Dental Insurance

Insurance company:____

Subscriber's Social Security #______________Group # ______________ID # ______________

Address:____________________ City: ____________State: ______

Whose name is this insurance under?____

Primary Insured Date of Birth: ____

Employer offering this insurance?______________________ Phone: ________

Secondary Dental Insurance

Insurance company:____

Subscriber's Social Security #______________Group # ______________ID # ______________

Address:____________________ City: ____________State: ______

Whose name is this insurance under?____

Secondary Insured Date of Birth: ____

Employer offering this insurance?______________________Phone: ______________

Dental History

Reason for today's visit: ____

Date of last dental care visit: ______________Date of last dental x-rays: ______________

Dentist's name: ______________________Phone: ______________________

Medical History

Your physician: ______________________________ Date of last visit: ______________________

Gender: ______________ Height: ______________ Weight (lbs) ______________________

Have you had any surgeries? ❑ Yes ❑ No

If yes, describe: ____

Have you ever had a blood transfusion? ❑ Yes ❑ No

If yes, give approximate dates: ____

Women: are you pregnant? ❑ Yes ❑ No

Are you nursing? ❑ Yes ❑ No

Are you taking birth control? ❑ Yes ❑ No

Check if you have or have had any of the following:

❑ Anemia
❑ Arthritis, rheumatism
❑ Artificial heart valves
❑ Artificial joints, pins, etc.
❑ Asthma
❑ Bleeding abnormally
❑ Blood disease
❑ Bronchitis
❑ Cancer
❑ Chemical dependency
❑ Chemotherapy
❑ Chest Pain
❑ Coronary artery disease
❑ Circulatory problems
❑ Congenital heart lesions
❑ Diabetes
❑ Dementia
❑ Epilepsy
❑ Fainting
❑ Glaucoma
❑ Headaches
❑ Heart Attack
❑ Heart murmur
❑ Heart problems
❑ Heart surgery
❑ Heart valve
❑ Hemophilia
❑ Hepatitis
❑ High blood pressure
❑ HIV AIDS
❑ Jaw pain
❑ Kidney disease
❑ Liver disease
❑ Low blood pressure
❑ Mitral valve prolapse
❑ Osteoporosis
❑ Pneumonia
❑ Implants
❑ Radiation treatment
❑ Respiratory disease
❑ Rheumatic fever
❑ Scarlet fever
❑ Sexually transmitted disease
❑ Sinus/nasal problems
❑ Sleep apnea
❑ Stroke
❑ Swelling of feet or ankles
❑ Thyroid problems
❑ Tobacco use
❑ Tonsillitis
❑ Tuberculosis

List medications you are currently taking and the related diagnosis:

Medication	Diagnosis

Please list any allergies you may have:

Allergy	Allergy

To the best of my knowledge, the above information is complete and correct.
I understand that it is my responsibility to inform my doctor if I or my minor child has a change in health.

Patient or Guardian Signature

Date