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PLEASE **PRINT**.

DATE ____/____/____

PATIENT'S NAME: _____ DATE OF BIRTH ____/____/____
(LAST) (FIRST) (MI)

I PREFER TO BE CALLED: _____ SEX ____ MARITAL STATUS ____ E-MAIL _____

ADDRESS: _____
(CITY, STATE) (ZIP)

HOME PHONE (____) _____ WORK PHONE (____) _____ CELL PHONE (____) _____

EMPLOYER OR SCHOOL: _____ OCCUPATION _____

PATIENT'S ID # (SOCIAL SECURITY #) _____ DRIVERS LICENSE #: _____

NAME & PHONE # OF PERSON TO CONTACT IN CASE OF EMERGENCY: _____

WHO REFERRED YOU TO OUR OFFICE? _____

INSURANCE INFORMATION

PRIMARY

NAME OF INSURED: _____ DATE OF BIRTH ____/____/____ ID OR SSN: _____

EMPLOYER: _____ WORK PHONE: _____ RELATIONSHIP TO PATIENT: _____

NAME OF INSURANCE COMPANY: _____ ADDRESS: _____

INSURANCE COMPANY PHONE #: _____ GROUP #: _____

SECONDARY

IF YOU HAVE ANY OTHER DENTAL INSURANCE, PLEASE FILL OUT THE INFORMATION BELOW FOR 2ND COVERAGE.

NAME OF INSURED: _____ DATE OF BIRTH ____/____/____ ID OR SSN: _____

EMPLOYER: _____ WORK PHONE: _____ RELATIONSHIP TO PATIENT: _____

NAME OF INSURANCE COMPANY: _____ ADDRESS: _____

INSURANCE COMPANY PHONE #: _____ GROUP #: _____

HISTORY

1. THE NAME AND PHONE NUMBER OF YOUR PRIMARY PHYSICIAN _____

2. HAS YOUR DOCTOR EVER TOLD YOU THAT YOU REQUIRE ANTIBIOTICS BEFORE DENTAL TREATMENT? _____

3. HAVE YOU EVER HAD A SERIOUS/DIFFICULT PROBLEM ASSOCIATED WITH ANY PREVIOUS DENTAL WORK? _____

4. DO YOU LIKE YOUR SMILE? _____ 5. DO YOUR GUMS EVER BLEED? _____

6. HOW MANY TIMES A WEEK DO YOU FLOSS? _____ 7. HOW MANY TIMES A DAY DO YOU BRUSH? _____

8. ARE YOU TAKING ANY MEDICATION, DRUGS, OR PILLS NOW? _____ IF YES, NAME AND DOSAGE _____

9. ARE YOU ALLERGIC TO ANY MEDICATION? _____ IF SO, WHAT? _____

10. WOMEN; ARE YOU PREGNANT? _____ NURSING? _____ TAKING BIRTH CONTROL PILLS? _____

11. DO YOU USE TOBACCO PRODUCTS? _____

MEDICAL HISTORY

HEART (SURGERY, DISEASE, ATTACK)	Y	N	EMPHYSEMA	Y	N	SINUS TROUBLE	Y	N
HEART MURMUR	Y	N	ASTHMA	Y	N	THYROID PROBLEMS	Y	N
HIGH BLOOD PRESSURE	Y	N	TUBERCULOSIS	Y	N	CONTACT LENS	Y	N
MITRAL VALVE PROLAPSE	Y	N	HIGH CHOLESTEROL	Y	N	ULCERS	Y	N
ARTIFICIAL HEART VALVE	Y	N	HAYFEVER	Y	N	DIET (SPECIAL/RESTRICTED)	Y	N
PACEMAKER	Y	N	LATEX SENSITIVITY	Y	N	ARTHRITIS/RHEUMATISM	Y	N
RHEUMATIC FEVER	Y	N	ALLERGIES / HIVES	Y	N	ARTIFICIAL JOINTS	Y	N
CONGENITAL HEART DISEASE	Y	N	BRUISE EASILY	Y	N	TRANSPLANT	Y	N
CHEST PAIN	Y	N	ANEMIA	Y	N	CANCER	Y	N
LIVER DISEASE	Y	N	SWOLLEN ANKLES	Y	N	VENEREAL DISEASE	Y	N
YELLOW JAUNDICE	Y	N	KIDNEY DISEASE	Y	N	A.I.D.S. / HIV	Y	N
BLOOD TRANSFUSION	Y	N	CHEMOTHERAPY	Y	N	NEUROLOGICAL DISORDER	Y	N
HEMOPHILIA	Y	N	COLD SORES (HERPES VIRUS)	Y	N	NERVOUS / ANXIOUS	Y	N
SICKLE CELL DISEASE	Y	N	HEADACHES	Y	N	PSYCHIATRIC CARE	Y	N
DIABETES	Y	N	MIGRAINES	Y	N	PSYCHOLOGICAL CARE	Y	N
HEPATITIS A (INFECTIOUS)	Y	N	FAINTING or DIZZY SPELLS	Y	N	CORTISONE MEDICATION	Y	N
HEPATITIS B	Y	N	EPILEPSY or SEIZURES	Y	N	BISPHOSPHONATE (ARELIA, ACTONEL, ZMETOR, FOSOMAX)	Y	N
HEPATITIS C	Y	N	STROKE	Y	N	RADIATION THERAPY	Y	N
CHRONIC COUGH	Y	N	GLAUCOMA	Y	N	FEN-PHEN (USED)	Y	N

I UNDERSTAND THE ABOVE INFORMATION IS NECESSARY TO PROVIDE ME WITH DENTAL CARE IN A SAFE AND EFFICIENT MANNER, I HAVE ANSWERED ALL QUESTIONS TO THE BEST OF MY KNOWLEDGE. SHOULD FURTHER INFORMATION BE NEEDED, YOU HAVE MY PERMISSION TO ASK THE RESPECTIVE HEALTH CARE PROVIDER OR AGENCY, WHO MAY RELEASE SUCH INFORMATION TO YOU. I WILL NOTIFY THE DOCTOR OF ANY CHANGE IN MY HEALTH OR MEDICATION.

PATIENT / GUARDIAN SIGNATURE _____ DATE _____

DOCTOR INITIAL _____
