OFFICE OF DR. CHARLIE TOWE, DDS

LET'S GET ACQUAINTED!!

PATIENT INFORMATION...

NAME_____AGE____BIRTHDAY_____SEX____
Parent or Guardian if patient is a minor_____
ADDRESS_____CITY_____STATE___ZIP_____
HOME#_____WORK#_____CELL#_____
MARITAL STATUS: ☐Single ☐Married ☐Divorced ☐Widowed
PATIENT'S EMPLOYER:_____OCCUPATION_____
SOCIAL SECURITY #_____DENTAL INSURANCE ☐YES ☐NO
INSURANCE COMPANY_____I.D.#_____
WHO REFERRED YOU TO OUR OFFICE_____
FORMER DENTIST_____MEDICAL DOCTOR_____
PERSON RESPONSIBLE FOR ACCOUNT_____

FAMILY INFORMATION...

SPOUSES NAME_____BIRTHDAY_____
SPOUSES EMPLOYER_____WORK#_____
SOCIAL SECURITY #_____DENTAL INSURANCE ☐YES ☐NO
INSURANCE COMPANY_____I.D.#_____

IN THE EVENT OF AN EMERGENCY...

NAME OF RELATIVE OR FRIEND_____RELATIONSHIP_____
HOME#_____ WORK#_____ CELL#_____

YOUR MEDICAL INFORMATION...

****Mark Y or N after each question...Do you have or ever had any of the following?****

☐Y ☐N ABNORMAL BLEEDING	☐Y ☐N FAINTING SPELLS	☐Y ☐N SEIZURES
☐Y ☐N ALCOHOL ABUSE	☐Y ☐N FEVER BLISTERS	☐Y ☐N RHEUMATIC FEVER
☐Y ☐N ALLERGIES	☐Y ☐N FREQUENT HEADACHES	☐Y ☐N RADIATION THERAPY
☐Y ☐N ANEMIA	☐Y ☐N HIV+/AIDS	☐Y ☐N PSYCHIATRIC PROBLEMS
☐Y ☐N ANGINA PECTORIS	☐Y ☐N HEART ATTACK/STROKE	☐Y ☐N PACE MAKER
☐Y ☐N ARTHRITIS	☐Y ☐N HEART SURGERY	☐Y ☐N MITRAL VALVE PROLAPSE
☐Y ☐N ARTIFICIAL HEART VALVE	☐Y ☐N HEMOPHILIA	☐Y ☐N HIGH BLOOD PRESSURE
☐Y ☐N ARTIFICIAL JOINT	☐Y ☐N HEPATITIS B	☐Y ☐N HEPATITIS C
☐Y ☐N ASTHMA	☐Y ☐N EPILEPSY	☐Y ☐N EMPHYSEMA
☐Y ☐N CANCER	☐Y ☐N DRUG ABUSE	☐Y ☐N TAKING MEDICATION
☐Y ☐N DIABETES	☐Y ☐N TOBACCO USE	☐Y ☐N ARE YOU PREGNANT?

*** LIST ANY MEDICATIONS YOU ARE TAKING ON THE BACK OF THIS FORM***

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ASPIRIN ☐CODEINE ☐PENICILLIN ☐DENTAL ANESTHETICS ☐LATEX_____

SIGNATURE:_____**DATE:**_____