GAYNOR FAMILY DENTAL
Mark A. Gaynor D.D.S., Paul R. Gaynor D.D.S.

Patient Information and Medical History

First Name: ___________________ Last Name: ___________________ M____

M___ F___ Minor___ Single___ Married___ Date of Birth: __/__/__

Street Address: __________________________ City: ___________________

State: ________________ Zip Code: ____________

Telephone:(Home)_____________(Cell)____________Email:_______________

Place of Employment/School: __________________

Occupation: ________________________________

Social Security Number: _____________ Driver's License: ________________

Dental Insurance Company: ___________________ Group #: ______________

Have any member(s) of your family been treated in our office? (yes no)

Who may we thank for referring you to our office? ________________________

Spouse *OR* Parent Information

Father/Husband: __________________

____
Street City State/Zip

________________/________________
Home Phone Cell Phone

____
(MM/DD/YYYY) SS#

____
Employer

____
Dental Insurance Group #

Mother/Wife: __________________

____
Street City State/Zip

________________/________________
Home Phone Cell Phone

____
(MM/DD/YYYY) SS#

____
Employer

____
Dental Insurance Group #

Person Responsible for Account

Patient____ Father/Husband____ Mother/Wife____ Guardian____

Who is your personal physician?____________________ Doctor's office location:_______________

Date of last physical exam: __/__/__ Doctor's phone number:________________________

Are you in good health?_________________________
Are you currently under medical care? And what for?
____
Do you take medication regularly?________________
____
Do you need to take an antibiotic before a dental procedure?____________________________________

Are you aware of any changes in your health in the past year?____
____
____
Have you ever been hospitalized? And what for?
____
____

Do you have or have you ever been treated for any of the following: (circle "Y" for yes or "N" for no)

Heart disease/attack	(Y/N)	Angina Pectoris	(Y/N)	Rheumatic Fever	(Y/N)	Jaundice	(Y/N)
Congenital Heart Lesion	(Y/N)	Radiation Treatment	(Y/N)	Excessive Bleeding	(Y/N)	Anemia	(Y/N)
Coronary Surgery	(Y/N)	Kidney disease	(Y/N)	Bleeding Disorder	(Y/N)	Stroke	(Y/N)
Artificial Heart Valve	(Y/N)	Tuberculosis	(Y/N)	Liver problems	(Y/N)	Diabetes	(Y/N)
Heart Pacemaker	(Y/N)	Hay Fever/Allergies	(Y/N)	I am on dialysis	(Y/N)	Epilepsy	(Y/N)
High Blood Pressure	(Y/N)	HIV Positive (AIDS)	(Y/N)	Celiac Disease	(Y/N)	Asthma	(Y/N)
Low Blood Pressure	(Y/N)	Arteriosclerosis	(Y/N)	Emphysema	(Y/N)	Arthritis	(Y/N)
Mitral Valve Prolapse	(Y/N)	Heart Murmur	(Y/N)				
Hepatitis A(Infectious)	(Y/N)	Chew tobacco?	(Y/N)	Cancer	(Y/N)What type? _________		
Hepatitis B/C(Serum)	(Y/N)	Do you smoke?	(Y/N) How often?__________				

Have you ever experienced a rash, itching, or other reaction after use of any of these medications?(Check if YES)

__Aspirin __Penicillin __Latex
__Local Anesthetics __Erythromycin __Sedatives
__Codeine __Tetracycline __ Sulfa
__Iodine __Other Antibiotics

Is there any other medical conditions about you which we should know? Your medical health may affect our dental treatment.______________________________
____
____

Do you have, or have you experienced:

__Shortness of breath on mild exertion
__Chest pain after/during exertions
__Swollen ankles
__Tumor/abnormal growth
__Do you have dry mouth?
__Serious trouble at previous dental visit(s)
__Any artificial replacements and/or implants?
__Are you currently pregnant?
__Do you take birth control pills?
__Do you take estrogens or hormones?

Date of last teeth cleaning: __/__/__

I authorize the release of any dental information necessary to process an insurance claim. I authorize payment of dental benefits to the name provided for professional services rendered. I also understand that when my dental insurance coverage excludes or does not fully cover professional services rendered, I am responsible for the account balance in full.

Patient/Legal Guardian Signature: __________________ Date: __/__/__ Dr. Signature:________________________

Review Date	Changes in Health Status	Patient Signature	Dr.'s Signature