Please fill out information sheets (two pages), including all insurance information. An 800 # to verify benefits would be appreciated. Return them to our office in the enclosed self-addressed envelope as soon as possible. Thanks!

JODY S. HARRISON, D.D.S.

PATIENT INFORMATION RECORD

Welcome to our office. Please answer all questions. This information is confidential and will help us serve you better. If at any time you have any questions regarding your treatment, your appointments, or fees, please ask.

NAME: (First)___________________(M. Initial)____(Last)_________________________
NAME YOU WISH TO BE CALLED_______________________________MARITAL STATUS________
DATE OF BIRTH_______________________
ADDRESS____
CITY_________________________________STATE_________________ZIP CODE____________
MAILING ADDRESS (IF DIFFERENT)____
SOCIAL SECURITY #_________________________DRIVER LICENSE #_____________________
HOME PHONE_______________________________CELL #________________________________
E-Mail Address:____

EMPLOYER____
ADDRESS____
OCCUPATION__________________________________WORK PHONE #_____________Ext.______

SPOUSE____________________________________EMPLOYER_____________________________
BUSINESS ADDRESS____
PREFERRED PHONE #____

PERSON RESPONSIBLE FOR PAYMENT____

IF PATIENT IS A MINOR, WHO HAS CUSTODY?____
IF MINOR PLEASE LIST PARENTS OR GUARDIAN INFORMATION ABOVE RE: EMPLOYER, DRIVERS LICENSE, SOCIAL SECURITY #

TO WHOM MAY WE SPEAK WITH CONCERNING YOUR PERSONAL HEALTH INFORMATION:

____
(Remains in effect until revoked by the patient)
EMERGENCY CONTACT OTHER THAN SPOUSE:____
HOME PHONE:_________________________CELL #____________________________________
ADDRESS______________________________CITY_____________ STATE ______ ZIP_______
RELATIONSHIP TO YOU____

FAMILY PHYSICIAN________________________________DATE OF LAST MEDICAL EXAM______
GENERAL DENTIST_________________________________DATE OF LAST DENTAL EXAM_______

WHO REFERRED YOU TO THIS OFFICE____

IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE FOLLOWING:

INSURED NAME____INSURED BIRTH DATE_________
INSURED SOCIAL SECURITY #_____________________GROUP #__________________________
EMPLOYER PROVIDING INSURANCE____
INSURANCE COMPANY NAME____
INSURANCE COMPANY ADDRESS____

PLEASE LIST ANY OTHER DENTAL COVERAGE:
INSURED NAME____INSURED BIRTH DATE_________
INSURED SOCIAL SECURITY #___________________________GROUP #____________________
EMPLOYER PROVIDING INSURANCE____
INSURANCE COMPANY NAME____
INSURANCE COMPANY ADDRESS____

(CONTINUED)

DENTAL HISTORY:
Have you had previous periodontal treatments? ____________________ When? __________
How many times have you had your teeth cleaned in the last five years? __________
When was the last time? ______________________________
Have you ever had an extremely frightening experience with dentistry? __________
Explain: ______________________________
Have I treated any of your family or friends? ________ Who? ______________

MEDICAL HISTORY:
Are you being treated by a doctor at this time? ___________ For what? ____________
____
Are you wearing any medical skin patches or medical/hormonal implants? (please list)? ______________________________
List any medicines, drugs or pills you are taking (including blood thinners, Aspirin, or herbal products) ______________________________
____
____
____
____
Do you wear a sleeping device (CPAP mask) or a similar appliance? ______________
____
Do you smoke? _____________ How many packs per day? ______________
Have you tested positive for HIV? ______________________________

DO YOU HAVE ANY OF THE FOLLOWING? PLEASE MARK YES OR NO:

Heart disease ____________ Asthma ____________
Heart murmur ____________ Glaucoma ____________
Mitral valve prolapse _____ Ulcers ____________
Valve replacements ________ Anemia ____________
Joints replaced __________ Liver trouble ______
Rheumatic fever __________ Thyroid trouble ____
Bacterial endocarditis ____ Gland trouble ______
Pacemaker ________________ Excessive thirst ___
High blood pressure _______ Venereal disease ___
Low blood pressure ________ Bladder trouble ____
Clotting problems _________ Kidney trouble _____
Hepatitis ________________ History of cancer ______________
Epilepsy _________________ Family history of cancer ________
Diabetes _________________ Psychiatric treatment ___________
Tuberculosis _____________ Excessive bleeding when cut _____
Osteoporosis _____________ Arthritis (Rheumatoid) _______ (Osteoarthritis) ________
Lung trouble _____________ Metal pins, screws, or plates ______________________

Office use only:

BP: EKG:

CHOL: PHYS:

Have you ever taken Cortisone? _____ When & for how long? ______________________
Have you ever taken medication for osteoporosis (Fosamax, Actonel, etc)? ________
How long? ______________________________

ALLERGIES: (Please circle)
Antibiotics, Aspirin, Codeine, Penicillin, Lidocaine, Epinephrine, Demerol, or others ______________________________
____

Have you had major surgery? ____ When? ______ Any complications? __________________
____

For Women Only: Are you pregnant? ____ Have you reached menopause? __________

SIGNATURE: ______________________________ DATE ______________________