N. E. FARNEY, D.D.S.

1701 W. 40 Highway • Suite 203-204
Blue Springs, Missouri 64015
(816) 229-3277

Referred by ______________________

Patient Introduction

PATIENT

Mr.
Mrs.
Miss
Patient ____
Last Name First Name Middle

Social Security # ____________ Date of Birth ________ Sex ____ Marital Status ______ Home Phone ______________

Address ____
Street Apt. No. City State Zip

Employed By ______________ Spouse's Name ______________ Employed By ______________

Employer's Address ______________ Employer's Address ______________

Occupation ________ Bus. Phone ________ Occupation ________ Bus. Phone ________

Nearest friend or relative not living in the same household Relationship to Patient Phone

INSURANCE

INSURANCE INFORMATION (Be sure all information is listed)

Insurance — Include Private, Group, and Spouse

	Insurance Company Name	Policyholder (Subscriber)	Policy Number or Certificate Number
1.			
2.			
3.			

Will this claim be covered under Worker's Compensation? ☐ Yes ☐ No

If yes, Name of Company ______________ Address of Co. ______________

Ph. # ______________ Treatment Authorized by ______________

RESPONSIBLE PARTY

RESPONSIBLE PARTY

Please complete the section below, if someone other than the patient is responsible for the payment of services.

Mr.
Mrs.
Miss
Name ____
Address City State Zip

Home Phone ____________ Relationship to Patient ____________ Occupation ____________

Employer ____________ Employer's Address ____________ Bus. Phone ____________
City State Zip

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of services. I understand that where appropriate, credit bureau reports may be obtained.

Preferred Method of Payment: ☐ Cash ☐ Check ☐ Credit Card (Master Card/Visa)

______________ ______________________________
Date (today) Signature of Patient, or Parent, or Responsible Party

MEDICAL HISTORY

Physician ______________________________

1. Are you having pain or discomfort at this time? . . . . Yes No
2. Do you clinch or grind your teeth? . . . . Yes No
3. Have you been a patient in the hospital during the past two years? . . . . Yes No
4. Have you been under the care of a medical doctor during the past two years? . . . . Yes No
5. Are you allergic to (I.E., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? . . . . Yes No
6. Have you ever had any excessive bleeding requiring special treatment? . . . . Yes No
7. Circle any of the following which you have had or have at present:

Heart Failure	Emphysema	AIDS
Heart Disease or Attack	Cough	Hepatitis A (Infectious)
Angina Pectoris	Tuberculosis (TB)	Hepatitis (serum)
High Blood Pressure	Asthma	Liver Disease
Heart Murmur	Hay Fever	Yellow Jaundice
Rheumatic Fever	Sinus Trouble	Blood Transfusions
Congenital Heart Lesions	Allergies	Drug Addictions
Scarlet Fever	Diabetes	Hemophilia
Artificial Heart Valve	Thyroid Disease	Venereal Disease (Syphilis, Gonorrhea)
Heart Pacemaker	Cold Sores	Genital Herpes
Heart Surgery	Epilepsy or Seizures	X-ray or Cobalt Treatment
Artificial Joint	Arthritis	Chemotherapy (Cancer, Leukemia)
Anemia	Rheumatism	Fainting or Dizzy Spells
Stroke	Cortisone Medicine	Nervousness
Kidney Trouble	Glaucoma	Psychiatric Treatment
Ulcers	Pain in Jaw Joints	Sickle Cell Disease
Alcoholism		Bruise Easily

8. Approximate date of last dental visit? ______________________________
9. Approximate date when teeth were last cleaned? ______________________________
10. How often do you brush your teeth? ______________________________
11. Do your gums bleed while brushing? . . . . Yes No
12. Have you ever been instructed in proper care of your teeth & proper diet? . . . . Yes No
13. Would you like to retain your healthy natural teeth as long as possible? . . . . Yes No
14. Are you self-conscious about the appearance of your teeth? . . . . Yes No
15. Do heat, cold, or sweets cause pain in your mouth? . . . . Yes No
16. Do you have any other pain in your mouth? . . . . Yes No
17. Have you ever had X-Ray Therapy? . . . . Yes No
18. WOMEN: Are you pregnant now? . . . . Yes No
19. List any medications you are currently taking ______________________________

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

____

Date Signature of Doctor Signature of Patient, Parent or Guardian

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