



MICHAEL E. FISHER, DDS

Patient's Full Name _____	Spouse's Name _____
Home # _____	Spouse's Date of Birth _____
Cell # _____	Spouse's Employer _____
Street Address _____	Address _____
P. O. Box _____	Phone _____
City _____ Zip _____	Spouse's Social Sec. # _____
Social Sec. # _____	Emergency Contact _____
Age _____ Date of Birth _____	Address _____
Sex _____ Physician _____	City _____ Zip _____
Your Employer _____	Phone # _____
Address _____	Do you have dental insurance? _____
Phone # _____	Insurance Co. _____

1. Do you take any medicine regularly? YES NO
2. Do you take cortisone now, or in the last 6 months? YES NO
3. Have you ever had any reaction to any local anesthetic or any shot? YES NO
4. Have you ever had surgery or been hospitalized? YES NO
5. Have you ever had abnormal bleeding with previous extractions or surgery? YES NO
6. Can you take penicillin? YES NO
7. Are any of your activities limited? YES NO
8. Do you use tobacco products? YES NO
9. Women – Are you pregnant? YES NO What month? _____ Do you take birth control pills? YES NO
10. When was your last complete medical exam? _____
Results _____
11. Are you under the care of a physician now? YES NO
For what reason? _____
12. List all medicine that you cannot take _____
13. List all medicine taken in the past year _____
14. List all allergies _____

Have you ever had:	YES	NO		YES	NO		YES	NO
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	STD	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Joint Replacement Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Allergy to Latex	<input type="checkbox"/>	<input type="checkbox"/>

15. Home water supply: City Well
16. Do you have any medical problem not given above? _____
17. Are you satisfied with your previous dental care? _____
18. Have you ever had a bad dental experience? _____
19. Has the fear of discomfort kept you from having dental care? _____
20. Have you ever been given instructions on how to brush and floss your teeth? _____
21. What problems are you having with your mouth? _____
22. Whom may we thank for referring you to our office? _____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize my insurance company to pay to the dentist or dental group all insurance benefits, otherwise payable to me for services rendered.

I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.