Patient Information Sheet

Steven W. Spurrier, D.D.S., M.S.D.

Patient Information

Patient's Name – Last _____ First _____ Middle _____

Nickname _____ Age _____ Birthdate _____ Sex M F

Address – Street _____ City _____

State _____ Zip _____ Home Phone _____

Siblings _____ School _____

If patient is a minor, give parent or guardian's name _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Last Name _____ First _____ Middle _____ Marital Status _____

Address – Street _____ City _____

State _____ Zip _____ How long at this address? _____

Mailing Address (if different from above) _____

Previous Address (if less than 3 years) _____

Home Phone _____ Work Phone _____ Cell Phone _____

Birthdate _____ SSN _____ Relation to patient _____

Employer _____ Occupation _____ No. of years employed _____

Employer's address _____

Spouse's Name – Last _____ First _____ Middle _____

Birthdate _____ SSN _____ Relation to patient _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____ No. of years employed _____

Employer's address _____

Dental Insurance Information

Insured's Name _____ Insured's ID# _____

Insured's Employer _____ Insurance Co. _____

Address _____ Phone # _____ Insured's SSN _____

Do you have dual coverage? Yes No If yes, please complete the following information

Insured's Name _____ Insured's ID# _____

Insured's Employer _____ Insurance Co. _____

Address _____ Phone # _____ Insured's SSN _____

Emergency Contacts

Emergency contact (name and address) _____ Phone # _____

Patient's physician _____ Phone # _____

Patient's Dentist _____ Phone # _____

Please complete reverse side →

Has the patient ever had any of the following...

Yes	No	
[ ]	[ ]	Have any health problems (current or past)_____
[ ]	[ ]	Take any medications (current or past)_____
[ ]	[ ]	See a physician (current or past)_____
[ ]	[ ]	Have allergies (itching, rash, swelling, sensitivity)_____
[ ]	[ ]	Mouth-breathe or have trouble breathing through nose_____
[ ]	[ ]	Have a history of any illness or hospitalizations_____
[ ]	[ ]	Have any pain or clicking in the jaw joint or ear infections_____
[ ]	[ ]	Experience frequent headaches or head/neck pain_____
[ ]	[ ]	Play any wind instruments or violin_____

Does the patient...

Yes	No		Yes	No	
[ ]	[ ]	Heart trouble, congenital lesions	[ ]	[ ]	Asthma
[ ]	[ ]	Heart Murmur	[ ]	[ ]	Kidney involvement
[ ]	[ ]	Skin rash, hives	[ ]	[ ]	Epilepsy
[ ]	[ ]	Hepatitis, liver involvement	[ ]	[ ]	Malignancies
[ ]	[ ]	Cold sores, fever blisters, cankers	[ ]	[ ]	Aids / HIV
[ ]	[ ]	Hearing problems	[ ]	[ ]	Tuberculosis
[ ]	[ ]	Diabetes (family history)	[ ]	[ ]	Bleeding Disorder
[ ]	[ ]	Rheumatic Fever	[ ]	[ ]	Anemia
[ ]	[ ]	Nervousness, hyperactivity	[ ]	[ ]	Mononucleosis
[ ]	[ ]	Thyroid disorders (family history)	[ ]	[ ]	Arthritis
[ ]	[ ]	Jaundice	[ ]	[ ]	Scarlet fever
[ ]	[ ]	Venereal disease	[ ]	[ ]	Ulcers, internal bleeding
[ ]	[ ]	Prolonged bleeding	[ ]	[ ]	Emphysema
[ ]	[ ]	Liver disease	[ ]	[ ]	Fainting, dizziness
[ ]	[ ]	High or low blood pressure	[ ]	[ ]	Excessively swollen ankles
[ ]	[ ]	Arteriosclerosis or stroke	[ ]	[ ]	Shortness of breath
[ ]	[ ]	Chest pain on mild exertion	[ ]	[ ]	Tumors or abnormal growth
[ ]	[ ]	Prostate disorders	[ ]	[ ]	Radiation treatment
[ ]	[ ]	Glaucoma	[ ]	[ ]	Contact Lenses
[ ]	[ ]	Psychiatric Treatment_____	[ ]	[ ]	Emotional problems or tensions
[ ]	[ ]	Blood Transfusion, when_____	[ ]	[ ]	Trauma to face, chin or jaw

Is the patient...

Yes	No		Yes	No	
[ ]	[ ]	Losing / gaining weight	[ ]	[ ]	Often exhausted or fatigued
[ ]	[ ]	Often thirsty	[ ]	[ ]	Highly stressed
[ ]	[ ]	A smoker	[ ]	[ ]	Pregnant
[ ]	[ ]	Subject to frequent headaches	[ ]	[ ]	Taking birth control
[ ]	[ ]	Often nervous, uptight	[ ]	[ ]	Presently in menopause
[ ]	[ ]	Often unhappy or depressed	[ ]	[ ]	Past menopause

Please explain any "Yes" answers to questions above, or a family history of the above conditions.

_____

_____

Please explain the main orthodontic concerns of the patient and what the patient would like orthodontics to accomplish. _____

_____

I certify that the information provided is accurate and that where appropriate, credit bureau reports may be obtained. Any changes to the medical history of the patient should be reported to Spurrier Orthodontics.

Signature_____ Date_____

Guardian Signature if patient is a minor