Decatur Family Dentistry
Robert Murav, D.D.S.

Patient Information Date___/___/___

Name_____Male/Female_____

The name you would like to be called_____

Address_____

City_____ State_____ Zip Code_____

Birth Date___/____/____ Phone: Home ( ) _____

E-mail address_____ Work ( ) _____

Cell ( ) _____

Social Security #_____-_____-_____ Marital Status_____

Place of Employment or School _____ (Grade) _____

Dental Insurance Company_____ Group # _____

Have any members of your family ever been treated at our office? _____

If yes, whom _____

How did you hear about our office _____

Family Information

Spouse's information (for minors please fill out both parents)

Billing address	Other parent
Name _____	Name _____
Address _____	Address _____
_____	_____
Birth date _____	Birth date _____
Social Security # _____	Social Security # _____
Employer _____	Employer _____
Dental Insurance Co. _____	Dental Insurance Co. _____
Group # _____	Group # _____

Decatur Family Dentistry accepts and will bill most insurance companies, but I understand that I am ultimately responsible for all costs of my dental treatment. I hereby authorize my group insurance to make payment directly to Decatur Family Dentistry. I authorize Decatur Family Dentistry to administer such medications, perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this form is correct to the best of my knowledge and if any changes occur I will inform Decatur Family Dentistry. I also give permission to Decatur Family Dentistry to use photographs, voice recordings, and/or X-rays for teaching purposes (without patient's name)

In case of emergency, contact: _____

Phone # _____ Address _____

Person responsible for this account _____

Signature_____ Date ____/____/____

Relationship to the patient _____

Medical and Dental History

Purpose of today's visit? _____

Previous dentists name? _____

Anything we need to know to better satisfy your dental needs? _____

List all surgeries, hospitalizations, and serious illness in the last 5 years _____

_____

Physicians name _____

Do you have any current medical problems? _____

List any medications you are taking (include vitamins) _____

_____

Are you pregnant? _____ **Due date** ____/____/_____

Do you smoke or use tobacco? _____ **How much a day?** _____

Do you like the way your teeth look? _____

Are your teeth sensitive to hot, cold and/or sweets? _____

Do you have or have you had any of the following:

YES	NO		YES	NO		YES	NO	
___	___	Abnormal Bleeding	___	___	Emphysema	___	___	Low Blood Pressure
___	___	Alcohol Abuse	___	___	Epilepsy	___	___	Mitral Valve
___	___	Allergies	___	___	Fainting Spells	___	___	Pace Maker
___	___	Anemia	___	___	Fever Blisters	___	___	Psychiatric Problems
___	___	Angina Pectoris	___	___	Frequent Headaches	___	___	Radiation Therapy
___	___	Arthritis	___	___	Glaucoma	___	___	Rheumatic Fever
___	___	Artificial Bones	___	___	Hay Fever	___	___	Seizures
___	___	Artificial Heart	___	___	Heart Attack	___	___	Shingles
___	___	Asthma	___	___	Heart Surgery	___	___	Sickle Cell Disease
___	___	Blood Transfusion	___	___	Hemophilia	___	___	Sinus Problems
___	___	Cancer-Chemotherapy	___	___	Hepatitis A	___	___	Stroke
___	___	Colitis	___	___	Hepatitis B	___	___	Thyroid Problems
___	___	Congenital Heart	___	___	High Blood Pressure	___	___	Tuberculosis
___	___	Cosmetic Surgery	___	___	HIV-AIDS	___	___	Ulcers
___	___	Diabetes	___	___	Kidney Problems	___	___	Venereal Disease
___	___	Difficulty breathing	___	___	Liver Disease	___	___	Yellow Jaundice
___	___	Drug Abuse						

Are you allergic to/or have you reacted adversely to any of the following medications?

YES	NO		YES	NO	
___	___	Aspirin	___	___	Nitrous Oxide
___	___	Local Anesthetic	___	___	Codeine
___	___	Erythromycin	___	___	Penicillin
___	___	Latex	___	___	Sulfa
___	___	Any other Allergies	___	___	Metals or Jewelry

It is important that we know about any medical and dental history. This information will have a direct bearing on your treatment. This information is strictly confidential and will not be released without your permission.

OFFICE USE BELOW

Updates___/___/___ **Changes** _____

Updates___/___/___ **Changes** _____