Patient Name:				Date:
Birthdate:	Age:	Sex:	__Married __Child __Single	
Social Security #:			Drivers Lic. #:	
Home Address:				Home Phone:
City:		State:		Zip:
How did you find out about City Dental?				

Person to contact in case of emergency:

Name:________________________________ Phone#________________

Address:____

Closest relative not living with you:

Name:________________________________ Phone#________________

Address:____

Employer:		Occupation:
Work Address:		Work Phone:
City:	State:	Zip:
Insurance provided by work:		

Spouse information:

Spouse's name:		
Birthdate:	Social security:	Occupation:
Employer:		
Work address:		
Insurance proved through spouse's work:		

UPDATES (OFFICE USE ONLY)

MEDICAL INFORMATION

1. Are you having pain or discomfort at this time? ______ Yes No
2. Have you been a patient in the hospital during the past two years? ______ Yes No
3. Have you been under the care of medical doctor during the past two years? ______ Yes No
   Physician's Name ______ Phone # ______
   Address ______
4. Have you taken any medication or drugs during the past two years? ______ Yes No
5. Are you now taking any medication or drugs? ______ Yes No
   if yes, please list: ______
6. Are you sensitive or allergic to any medication or anesthetics? ______ Yes No

   if yes, please list: ______
7. Indicate which of the following you have had or have at present time. Circle "Yes" or "No" to each item.

Heart Failure	Yes	No	Artificial Joins	Yes	No	Allergy to Latex	Yes	No
Heart Disease or attack	Yes	No	Kidney Trouble	Yes	No	Hepatitis B (serum)	Yes	No
Angina	Yes	No	Ulcers	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Diabetes	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Thyroid Problems	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Glaucoma	Yes	No	Cold Sores/Fever Blister	Yes	No
Arteriosclerosis	Yes	No	Cancer	Yes	No	Blood Translusion	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Hemophilia	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Anemia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Heart Surgery	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Rheumatic fever	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Arthritis	Yes	No	Allergies or Hives	Yes	No	Yellow Jaundice	Yes	No
Rheumatism	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Cotisone Medicine	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Drug Addiction	Yes	No	Chemotherapy	Yes	No	Nervousness	Yes	No
Stroke	Yes	No	Hepatitis A (infections)	Yes	No	Tumors	Yes	No
Developmentaly Disabled	Yes	No	History of Phen-Fen	Yes	No			

8. Do you have now removable prosthetics (Full Dentures, Partial Dentures, Stayplates) ______ Yes No
   if yes, when it was done? Date: ______
9. Do your ankles swell during the day? ______ Yes No
10. Do you use more than two pillows to sleep? ______ Yes No
11. Have you lost or gained more than 10 pounds in the past year? ______ Yes No
12. Do you ever wake up from sleep and feel short of breath? ______ Yes No
13. Are you on a special diet? ______ Yes No
14. Do you have or have you had any disease, condition, or problem not listed? ______ Yes No
    if yes, please list: ______
15. Are you pregnant or are you nursing? ______ Yes No

I understand that above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and the best of my knowledge.

PATIENT SIGNATURE ______ DATE: ______

CONSENT:

1. I authorize release of any information relating to my treatment, I hereby authorize payment of the dental benefits to the Dr. Galina D.D.S.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time of services are rendered unless other arrangements have been made. In the event payment s are not received by the agreed upon dates, I understand that finance charge will be added to my account, in addition to any collection charges. I understand that where appropriate credit bureau reports may be obtained.
4. I understand that in the event where my insurance company is not paying for services rendered at City Dental, the amount due becomes my responsibility.
5. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient Signature ______ Name Print ______

Date: ______ Witness: ______ Reviewed By Dr. Galina D.D.S. ______