John Bain D.D.S.
Natural Family Dentistry

DATE: _____

Patient Information

FULL NAME: _____ DATE OF BIRTH: _____ SEX: M___ F___

SOCIAL SECURITY #: _____ PHONE Home: _____ Work: _____ Cell: _____

ADDRESS: _____ CITY: _____ STATE _____ ZIP: _____

EMAIL: _____ RESPONSIBLE PARTY: _____ PARENT: YES ___ NO ___

NAMES OF FAMILY MEMBERS: _____ HOBBIES: _____

WHO REFERRED YOU TO US? _____ EMERGENCY CONTACT _____ PHONE _____

PATIENT'S OCCUPATION: _____ PATIENT'S EMPLOYER: _____

Health History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions:

Medical Doctor: _____ Phone: _____

Are you under a physician's care now? Yes___ No___ If yes, please explain: _____
Have you ever been hospitalized or had a major operation? Yes___ No___ If yes, please explain: _____
Have you ever had a serious head or neck injury? Yes___ No___ If yes, please explain: _____
Are you taking any medications, pills, or drugs Yes___ No___ If yes, please list: _____

Do you use tobacco? Yes___ No___
Do you use controlled substances? Yes___ No___
Have you ever taken Fosamax, Zoneta, Aredia, Actonel, or Boniva? Yes___ No___

WOMEN: Are you: Pregnant/Trying to get pregnant? ___
Nursing ?___ Taking oral contraceptives? ___

Are you allergic to any of the following? (Please circle if yes)
Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other, please explain: _____

Do you have, or have you had, any of the following? (Please circle if yes)

AIDS/HIV Positive	Chest Pains	Frequent Headaches	Irregular Heartbeat	Scarlet Fever
Alzheimer's Disease	Cold Sores/Fever Blisters	Genital Herpes	Kidney Problems	Shingles
Anaphylaxis	Congenital Heart Disorder	Glaucoma	Leukemia	Sickle Cell Disease
Anemia	Convulsions	Hay Fever	Liver Disease	Sinus Trouble
Angina	Cortisone Medicine	Heart Attack/Failure	Low Blood Pressure	Spina Bifida
Arthritis/Gout	Diabetes	Heart Murmur	Lung Disease	Stomach/Intestinal Disease
Artificial Heart Valve	Drug Addiction	Heart Pace Maker	Mitral Valve Prolapse	Stroke
Artificial Joint	Easily Winded	Heart Trouble/Disease	Pain in Jaw Joints	Swelling of Limbs
Asthma	Emphysema	Hemophilia	Parathyroid Disease	Thyroid Disease
Blood Disease	Epilepsy or Seizures	Hepatitis A	Psychiatric Care	Tonsillitis
Blood Transfusion	Excessive Bleeding	Hepatitis B or C	Radiation Treatments	Tuberculosis
Breathing Problem	Excessive Thirst	Herpes	Recent Weight Loss	Tumors or Growths
Bruise Easily	Fainting Spells/Dizziness	High Blood Pressure	Renal Dialysis	Ulcers
Cancer	Frequent Cough	Hives or Rash	Rheumatic Fever	Venereal Disease
Chemotherapy	Frequent Diarrhea	Hypoglycemia	Rheumatism	Yellow Jaundice

Have you ever had any serious illness not listed above? ____ If yes, please explain: _____

Insurance Information

Name of Subscriber / Policy Holder: _____ Employer: _____ Relationship to Patient: _____

Social Security #: _____ Date of Birth: _____ Dental Insurance Company : _____

Phone: _____ Address: _____ Group #: _____

Financial Responsibility Statement

I am financially responsible for payment for the dental services rendered. Unpaid balances are subject to monthly statement preparation charges plus whatever expenses that occur in collection of fees due.

Signed: _____ Date: _____

John Bain D.D.S.
Natural Family Dentistry

82 South Southwinds Road
Farmington, AR 72730
(479)267-4900

Date: _____

Signature: _____

I consent for the office of Dr. John Bain to share my personal information with the following: (family, friends, etc.)

Name/Relationship:

1. _____/_____
2. _____/_____
3. _____/_____
4. _____/_____
5. _____/_____
6. _____/_____