

Charles C. Nunnally, D.D.S.

This patient information and consent for treatment form must be filled out completely and sign before any treatment can be rendered.

PERSONAL INFORMATION **INSURANCE INFORMATION**

Patient name _____
 Name I preferred to be called _____
 Address _____ Apt. # _____
 City _____ State _____ Zip _____
 Home # _____ Cell # _____
 Work # _____ Email _____
 Date of birth ____/____/____ Male Female
 Height _____ Weight _____ Single Married
 SSN # _____ DL# _____
 Person responsible for payment _____

Name of insured person _____
 Relationship to patient _____
 Date of birth ____/____/____ SSN# _____
 Dental Ins. Co. name _____
 Policy/Group # _____
 Insured's employer _____

EMERGENCY CONTACT

Name _____
 Phone _____
 Relationship to patient _____

INFORMATION FOR PATIENTS WHO ARE MINORS

Patient's/Guardian's name _____
 Address (if different) _____
 Date of Birth _____ Home # _____
 Work # _____ Cell # _____
 SSN# _____ DL# _____

REFERRED TO OUR OFFICE BY

Friend/relative _____
 Drove by office Yellow pages Website
 Insurance company
 Other _____

MEDICAL HISTORY OF PATIENT - CONFIDENTIAL

What dental concerns or problems do you have today? _____
 Your current Dental Health: Excellent Good Fair Poor
 Your current General Health: Excellent Good Fair Poor
 Your medical doctor _____ Date of last exam _____
 Address of med. doctor _____ Ph. # of med. doctor _____
 Please check the box if you have ever had any of the following: 4

Heart disease <input type="radio"/>	High blood pressure <input type="radio"/>	Diabetes <input type="radio"/>	Ulcers <input type="radio"/>
Heart murmur <input type="radio"/>	Low blood pressure <input type="radio"/>	Kidney disease <input type="radio"/>	Glaucoma <input type="radio"/>
Pacemaker <input type="radio"/>	Fainting spells <input type="radio"/>	Thyroid problems <input type="radio"/>	Arthritis <input type="radio"/>
Stroke <input type="radio"/>	Blood diseases <input type="radio"/>	Joint replacement <input type="radio"/>	Epilepsy <input type="radio"/>
Emphysema <input type="radio"/>	Prolonged bleeding <input type="radio"/>	HIV or AIDS <input type="radio"/>	Seizures <input type="radio"/>
Asthma <input type="radio"/>	Anemia <input type="radio"/>	Hepatitis _____ <input type="radio"/>	Cancer <input type="radio"/>
Tuberculosis <input type="radio"/>	Rheumatic fever <input type="radio"/>	Sinus trouble <input type="radio"/>	Any surgery <input type="radio"/>

ALLERGY TO:

Penicillin

Codeine

Latex

Local anesthesia

Other _____

Describe cancer or surgery (please include dates) _____
 If you have any other medical problems not listed please describe _____
 Please list any medications or prescriptions you are currently taking _____
 (If necessary, you may use the back of this form or attach a sheet to answer the medical questions.)
 Have you ever taken phen phen, redux, or pondimin? YES NO
 If female, are you pregnant? No Yes How long? _____ If female, are you nursing No Yes How long? _____
 Do you smoke? No Yes How long? _____ Have you had any blood transfusions? No Yes When? _____

CONSENT FOR TREATMENT

By my signature below, I consent to the examination and treatment by Dr. Charles C. Nunnally. I understand that dentistry is not an exact science and therefore the results of any treatments may vary from patient to patient. I understand that occasionally, additional treatment may be required. Also, by my signature below I hereby certify the correctness and completeness of the medical history information above. I also understand that I am responsible for payment of all fees and costs resulting from my treatment.

Patient's signature _____ Date _____
Custodial parent or legal guardian must sign for consent for treatment if patient a minor or legally incapacitated.

Witness _____ Date _____