Kenneth M. Schweizer, DDS, PA

Name_____Date_____

Address_____City_____State_____Zip_____

Home Phone_____Business_____Cell#_____

Alternate # to Call_____SSN_____

Date of Birth____/____/____Sex:___ M___ F Marital Status: ___S___ M___ D___W

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

How long has it been since you last saw a Dentist?_____

What is your primary concern about your teeth, smile, or breath?_____

_____

Occupation_____Employer_____

Address_____City_____State_____Zip_____

Dental Insurance Company
Name_____

Address_____City_____State_____Zip_____

Policy Number_____Group Number_____

Friend or relative we may contact in case of an emergency:

Name_____Address_____

City_____State_____Zip_____Phone_____

Authorization for release of information: I hereby authorize Dr. Kenneth M. Schweizer to release all information and x-rays with respect to myself or any of my dependents to any doctor or facility that has legitimate need for such information.

Signature of patient or parent:_____

Medical History

- Are you in good health? Yes No
- Have there been any changes in your general health within the past year? Yes No
- My last physical examination was on?_____
  Physicians Name_____Phone_____
- If you do not have a physician would you like us to recommend one to you? Yes No
- Have you been hospitalized or had a serious illness within the last five years? Yes No
- If so what was it?_____
- If female, are you pregnant? Yes No
- If female, do you take birth control pills? Yes No

Circle any of the following of which you have or have had in the past

High Blood Pressure	Cancer	Arthritis
Rheumatic Fever	Radiation Therapy	Gout
Mitral Valve Prolapse	Blood Disorders	Artificial Joints
Artificial Heart Valve	Diabetes	Glaucoma
Heart Murmur	Skin Disease	Lung Disease
Bypass Surgery	Psoriasis	Asthma
Heart Pacemaker	Kidney Disease	Emphysema
Angina/ Chest Pain	Thyroid Disease	Tuberculosis
Stroke	Liver Disease	Psychiatric Treatment
Seizures	Hepatitis	Venereal Disease
Steroid Therapy	Disease of the Digestive Tract	AIDS or HIV
Shortness of Breath	Stomach Ulcers	Epilepsy

- Do you have any other disease, condition, or problem not listed above? Yes No
  If yes, explain:_____
  _____
  _____

- Are you allergic to any drugs or medications? Yes No
  If yes, please list:_____
  _____
  _____

- Are you taking any medications now? (Include non-prescription) Yes No
  If yes, please list:_____
  _____
  _____

Have you had any serious trouble associated with any previous dental treatment? Yes No
Do you premedicate with antibiotics for any reason? Yes No

I have read and understand the above and have answered the questions to the best of my ability.

Patient's Signature:_____Dated:_____