

Robert H. DeWitt, D.D.S., P.C

Name: _____ Nickname: _____

Address: _____

City _____ State _____ Zip: _____

Phone: (Home) _____ (Business) _____ (Cell) _____

E-Mail Address: _____

Employed By: _____ Occupation: _____

Business Address: _____

Whom may we thank for referring you? _____

Do you have Dental Insurance? _____ Who is the policy holder? _____

Spouse's Name: _____ Name and ages of children: _____

In case of emergency, whom should we notify?

Name: _____ Phone: _____

Name of person responsible for account, if other than patient:

Name: _____ Address: _____

Payment is expected at the time services are rendered unless prior arrangements have been made. I understand that the payment of my bill is my legal obligation. All filings of insurance papers and confirmation of insurance payments to be made by my insurance company are my responsibility. Any assistance in this matter granted by the above doctor and/or staff is given strictly as a courtesy and implies no responsibility on their part for filing, following-through or confirmation. If this account is placed in the hands of an attorney for collection, I agree to pay from the date the payment was due, plus all costs of collection at the rate of 1.5% on the amount due per month, including attorney fees.

Signature: _____ Date: _____

MEDICAL HISTORY:

Date of birth: _____

Primary Care Physician: _____

Date of last complete physical: _____

Do you have or have had any of the following? Please list the dates of occurrence.

- | | |
|--------------------------------------|--|
| _____ Abnormal heart problems | _____ Malignancies |
| _____ Abnormal blood pressure | _____ Nervous / Psychiatric problems |
| _____ Anemia | _____ Rheumatic fever |
| _____ Arthritis | _____ Radiation / Chemotherapy |
| _____ Asthma | _____ Sinus problems / Nasal obstruction |
| _____ Circulatory problems | _____ Stroke |
| _____ Diabetes or Hypoglycemia | _____ Surgery |
| _____ Epilepsy or seizures | _____ Thyroid / Hormonal disorders |
| _____ Excessive bleeding or bruising | _____ Tuberculosis |
| _____ Heart Murmur | _____ Ulcer / Stomach / GI problems |
| _____ Hepatitis | |
| _____ HIV exposure | _____ Other, please list: |
| _____ Latex Allergy | |

Women: Are you pregnant? _____ Due Date: _____ Birth Control: _____

Please complete the reverse side

Please list allergies to medications: _____

Please list all other allergies: _____

What antibiotics can you take? _____

Please list all medications, vitamins, and herbs you are currently taking:

Non-Prescription Vitamins, Herbs and other Supplements: _____

Medication: _____
Dose/Frequency: _____
Reason for taking: _____

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Dose/Frequency: _____
Reason for taking: _____

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Dose/Frequency: _____
Reason for taking: _____

Signature: _____ **Date:** _____

Date: _____ Initial: _____ Date: _____ Initial: _____

Date: _____ Initial: _____ Date: _____ Initial: _____

Date: _____ Initial: _____ Date: _____ Initial: _____

Date: _____ Initial: _____ Date: _____ Initial: _____

Date: _____ Initial: _____ Date: _____ Initial: _____