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

Name: _____ Nickname: _____

Address: _____

City _____ State_____ Zip: _____

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

Email Address:_____

Employed By: _____ Occupation: _____

Business Address: _____

How did you hear about us? _____

Do you have Dental Insurance? ____Name of policy holder _____Policy Holder D.O.B:_____

Spouse's Name: _____Name 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-though 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 blood pressure
_____Anemia
_____Arthritis
_____Asthma
_____Cancer / Malignancies
_____Chemotherapy / Radiation
_____Circulatory problems
_____Diabetes or Hypoglycemia
_____Epilepsy or Seizures
_____Excess bleeding or bruising
_____Heart Murmur
_____Heart problems
_____Hepatitis
_____HIV exposure
_____Joint Replacements
_____Nervous / Psychiatric problems
_____Osteoporosis / Osteopenia
_____Rheumatic fever
_____Snoring / Sleep Apnea
_____Stroke, Date: _____
_____Thyroid / Hormonal disorders
_____Tuberculosis
_____Ulcer / Stomach / GI problems
_____Surgery Date and Type:

_____Other, Please list:

Women: Are you pregnant? _____Due Date: _____Birth Control: _____

Please complete the reverse side

Please list allergies to medications: _____

_____

Please list all other allergies: _____

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

Non-Prescription Vitamins, Herbs and other Supplements: _____

_____

Prescription Medications:

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

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

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Dose/Frequency: _____
Reason for taking: _____

Signature:_____ _____ **Date**:_____ _____

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

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

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