GARY R. SELBY, D.D.S., P.A.
General & Cosmetic Dentistry

PATIENT INFORMATION

Date_____

Patient_____

Address_____

_____
City State Zip

Sex: Male/Female Age_____ DOB_____

Patients SS#_____

Drivers License_____

Occupation_____

Employer_____

Spouse's Name_____

DOB_____ SS#_____

Email Address_____

Whom may we thank for referring you?_____

DENTAL HISTORY

Reason for today's visit_____

Former Dentist-City/State_____

Date of last visit_____

Date of last dental X-rays_____

How often do you floss?_____brush?_____

Please circle if you have had any of the following:

Bad breath
Bleeding gums
Blisters on lips or mouth
Burning sensation on tongue
Chew on one side of mouth
Cigarette,pipe,or cigar smoking
Clicking or popping jaw
Dry mouth
Fingernail biting
Food collection between teeth
Foreign objects
Grinding Teeth
Sores or growths in your mouth
Gums swollen or tender
Jaw pain or tiredness
Lip or cheek biting
Loose teeth/broken fillings
Mouth breathing
Mouth pain,brushing
Ortho treatment
Pain around ear
Periodontal treatment
Sensitivity to cold,heat sweets, when biting

PHONE NUMBERS

Home_____ Work_____ Ext_____

Cell_____ Spouse's Cell/Work_____

IN CASE OF EMERGENCY CONTACT (Specify someone who does not live in your household.)

Name_____ Relationship_____ Phone_____

DENTAL INSURANCE

Who is responsible for your account?_____Relationship_____

Insurance Co._____Group #_____

Subscriber_____DOB_____SS#_____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage as stated above and assign directly to Dr. Gary Selby all insurance benefits, if any, otherwise payable to me the services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature Date Relationship

-CONTINUED ON THE NEXT PAGE-

HEALTH HISTORY

Physician's Name_____ Date of last visit_____

Please place a check if you have or have had the following:

AIDS_____
ANEMIA_____
ARTHRITIS, RHEUMATISM_____
ARTIFICIAL HEART VALVES_____
ARTIFICIAL JOINTS_____
ASTHMA_____
BACK PROBLEMS_____
BLEEDING ABNORMALLY _____
BLOOD DISEASE_____
CANCER_____
CHEMICAL DEPENDENCY_____
CHEMOTHERAPY_____
CIRCULATORY PROBLEMS_____
CONGENITAL HEART LESIONS_____
CORTISONE TREATMENTS_____
COUGH, PERSISTENT OR BLOODY_____
DIABETES_____
EMPHYSEMA_____
EPILEPSY_____
FAINTING OR DIZZINESS_____
GLAUCOMA_____
HEADACHES_____
HEART MURMER_____
HEART PROBLEMS_____
HEPATITIS TYPE____ _____
HERPES_____
HIGH BLOOD PRESSURE_____
HIV POSITIVE_____
JAUNDICE_____
JAW PAIN_____
KIDNEY DISEASE_____
LIVER DISEASE_____
LOW BLOOD PRESSURE_____
MITRAL VALVE PROLAPSE_____
NERVOUS PROBLEMS_____
PACEMAKER_____
PSYCHIATRIC CARE_____
RADIATION TREATMENT_____
RESPIRATORY DISEASE_____
RHEUMATIC FEVER_____
SCARLET FEVER_____
STROKE_____
SHORTNESS OF BREATH_____
SINUS TROUBLE_____
SKIN RASH_____
SPECIAL DIET_____
SWELLING OF FEET/ANKLES_____
SWOLLEN NECK GLANDS_____
THYROID PROBLEMS_____
TONSILLITIS_____
TUBERCULOSIS_____
ULCER_____
TUMOR/GROWTH HEAD/NECK_____
VENEREAL DISEASE_____

DO YOU WEAR CONTACT LENSES?_____

WOMAN: ARE YOU PREGNANT? DUE DATE_____ ARE YOU NURSING?_____

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

Pharmacy name and Phone Number_____

ALLERGIES

Please circle any allergies:

ASPIRIN LOCAL ANESTHTIC SULFA

BARBITURATES (SLEEPING PILLS) SULFA

CODEINE IODINE LATEX PENICILLIN

LOCAL ANESTETIC OTHER_____

Patient's (or Legal Guardian's) Signature_____Date_____

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UPDATES (TO BE FILLED IN AT FUTURE APPOINTMENTS)

Has there been any change in your health since your last dental appointment?_____

Are you taking any new medications? For what?_____

Patient's Signature_____Date_____

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Are you taking any new medications? For what?_____

Patient's Signature_____Date_____

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