Bryan J. Roy, D.D.S., M.S.D., P.C. **CONFIDENTIAL PATIENT HISTORY**
Practice Limited to Periodontics

PATIENT INFORMATION

Childs Name____Birthdate_______________________ Male Female

Home Phone Number___________________________________Patient's Dentist____________________________

Address______________________________City_______________________State_______________Zip__________

School____City____________________State_____________

Name of Mother/Guardian____________________________________Birthdate_____________________________

Social Security Number______________________________________Cell Phone Number____________________

Home Address________________________City_______________________State________________Zip_________

Employer____Work Phone Number____________________

Name of Father/Guardian______________________________________Birthdate____________________________

Social Security Number_______________________________________Cell Phone Number___________________

Home Address_________________________City_______________________State_______________Zip_________

Employer____Work Phone Number___________________

DENTAL INSURANCE INFORMATION

Name of Insured____Relationship to Patient__________________

Birthdate____Social Security Number___________________

Name of Employer____Work Phone Number____________________

Insurance Company______________________________Group Number__________________ID#_______________

Insurance Address________________________________City_________________State________Zip____________

DO YOU HAVE ADDITIONAL **DENTAL** INSURANCE YES NO IF YES, COMPLETE THE FOLLOWING:

Name of Insured____Relationship to Patient_________________

Birthdate____Social Security Number__________________

Name of Employer____Work Phone Number___________________

Insurance Company_____________________________Group Number___________________ID#_______________

Insurance Address_______________________________City________________State__________Zip____________

PATIENT MEDICAL HISTORY

In case of emergency, name of relative/friend not living with you ______________________Phone #__________

Patients Physician____ Phone #____________________

Referring Dentist__________________________ Family Dentist_________________________________

Present Health? Good_____________ Fair______________ Poor_____________

Circle any of the following, which you have had or have at present:

Heart Condition	Lung Disease	Diabetes
Anemia/Hemophilia	Tuberculosis (TB)	HIV/AIDS
Rheumatic Fever	Asthma	Hepatitis---Type_____
Cancer	Tonsilitis	Blood Transfusion
Epilepsy/Seizures	Allergies	Frequent Headaches
Latex Sensitivity	Skin Rashes/Hives	Other_______________

Are you presently taking any medicine or drugs (***prescription and over-the-counter***)? No Yes
If yes, list drug, dosage, and frequency____

Are you ***allergic*** to any drugs, or other substance**?** No Yes
If yes, please list ____

Are you now, or have you been under the ***care of a medical doctor*** during the last two years? No Yes
Have you ever been hospitalized or had surgery? No Yes
If yes, please explain ____

Have you ever had a reaction to a dental anesthetic? No Yes
Have you ever had complications or illness following dental treatment? No Yes
Have you ever had prolonged or unusual bleeding? No Yes
Have you ever had an injury or trauma to your face or jaw? No Yes

What do you perceive to be your main dental problem __________________________________
____
Describe any dental pain you have now____

Date of last cleaning _____________
Have I treated any of your family or friends? ____________ Who ______________________

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the dentist and dental staff at the next appointment without fail. I agree to pay for all services rendered (including those services not covered by my dental insurance) and, if necessary, any collection agency fees, attorney fees or cancellation charges. ***Dr. Roy has no agreement or relationship with any insurance company with the exception of Delta Dental Premier****. I have also received the patient information sheet.*

____ ___________________
Parent/Guardian Signature Date