Michael J. Doherty D.D.S., Michael R. Doherty D.D.S. & Daniel T. Doherty D.D.S.

Patient Information

Email:_____

Name:_____ Sex:___ ___Social Security #:_____

Address:_____ City_____ State_____ Zip_____

Home Phone:_____ ___Work Phone:_____ Cell Phone:_____ Birth Date:_____

Occupation:_____ Employer:_____ Address: _____

Spouse's Name:_____ Employer: _____

Who is responsible for this account?_____ Relationship:_____

Primary Dental Insurance:_____ Policy or Member #:_____

Secondary Dental Insurance:_____ Policy or Member #:_____

How did you learn of our office? _____

Medical History

Physician: _____ Approximate date of last physical:_____

Are you under any medical treatment now?_____ If so, for what? _____

Are you taking any drugs or medications?_____ If so, what? _____

Have you had any major operations? _____ If so, for what and when? _____

Are you allergic to anything? _____ If so, what? _____

Has anyone informed you that you had:

	YES	NO		YES	NO
A heart ailment?	_____	_____	Heart murmur?	_____	_____
High blood pressure?	_____	_____	Mitral valve prolapse?	_____	_____
Respiratory disease?	_____	_____	Rheumatic fever?	_____	_____
Diabetes?	_____	_____	Blood disease?	_____	_____
Yellow jaundice or hepatitis?	_____	_____	Tumors or growths?	_____	_____
HIV infection or AIDS	_____	_____	If so, where? _____		
Joint (Hip or Knee) Replacement	_____	_____			

	YES	NO
Women: Are you pregnant, breast-feeding, or taking birth control pills?	_____	_____

Dental History

	YES	NO
Have you ever had any unusual reactions to local anesthetic?	_____	_____

When was the last time you saw a dentist for treatment? _____

Do you feel there is anything else your doctor needs to know about your medical or dental condition? _____

_____

(Payment is due at time of service unless previous arrangements have been made. Collection fees will be added to accounts not kept current.)

Signature:_____ **Date:**_____

updated: _____ _____ _____ _____