Jeremy Gerber, DMD, P.A.

WELCOMES YOU

Date:_____

PERSONAL INFORMATION

Last Name _____ First Name _____ M.I._____

Home Address_____

City_____ State_____ Zip_____

Home Telephone_____ Cell Phone _____ Age _____ Date of Birth_____

Sex: Male or Female_____ Marital Status: Single, married, Divorced, Separated or Widowed

Social Security Number_____ Dr, Lic. #_____

List Major Credit Card #_____

Employed By_____ Business phone_____

Business Address_____ City_____ State_____ Zip_____

Person to call in case of Emergency: Name _____ Relationship _____ Phone_____

How are you paying for today's appointment? Cash _____ Credit Card _____ Check _____ Insurance _____ Other__

BY WHAT MEANS WERE YOU REFERED TO OUR OFFICE? _____

NAME OF THE PERSON REFERING YOU OR ADVERTISING METHOD_____

ARE YOU UNDER ANY HMO OR PPO PLAN? IF SO NAME_____ GROUP #_____

GENERAL HEALTH QUESTIONS

1. Do you have or have you had any of the following? Please CIRCLE the condition:

Heart Attack/Heart Trouble
Mitral Valve Prolapse
Rheumatic Fever/ Murmur
Blood Pressure (High or Low)
Stroke/ Kidney Disease
Heart Murmur/ Fever
Extreme Weight Loss/ Anorexia
Ulcers/ Prostate Problems
Allergic to nickel or other Metals
Periodontal Surgery
Palpitations

Thyroid Disease
Congenital Heart Disease
Anemia/ Blood Disorders
Arthritis/ Night Sweats
Diabetes/ Fainting Spells
Migraine Headaches
Cancer Treatment
Herpes Virus
Epilepsy/ Seizures
HIV Positive
TMJ Problems

Open Heart Surgery
Valve Replacement
Nervous Disorder
Asthma/ Hay Fever/Emphysema
Glaucoma/ Tumors or Growth
Hepatitis/ Liver Disorders
Radiation Treatment
Tuberculosis/ Blood Sputum
Venereal Disease/ Persistent Cough
Pregnancy-# of Months_____

Initials of DDS reviewing medical HX_____

2. Are you under the care of a physician at this time?..... YES NO
   If yes why? _____
3. Are you taking any drugs or medications..... YES NO
   If yes note name and dosage of each: _____
   Blood Thinners or Cortisone-like?..... YES NO
4. Are you allergic or have you reacted adversely to any medication,
   Food or other, or local anesthetic? If yes what _____ YES NO
5. Have you ever had knee or joint replacement or pins inserted?..... YES NO
6. Have you ever had any bleeding or clotting problems or bruise?..... YES NO
7. Do you usually heal quickly?..... YES NO
8. Do you bleed a long time or bruise quickly or ever had a blood transfusion?..... YES NO
9. Ever had teeth extracted or any oral surgery?..... YES NO
   Any difficulties? If yes explain _____
10. Do you smoke? ..... YES NO
11. Have you ever been hospitalized with an undiagnosed condition?..... YES NO
    If yes what is the illness or operation _____

Do you any disease not listed above? Explain _____ please complete reverse side