GREGORY P. SKINNER, DDS, PC
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Roanoke, VA 24012

DATE: _____

PATIENT INFORMATION

Name _____ Birth Date_____

Sex: ___M ___F Check Appropriate Status: ___Child ___Single ___Married ___Separated ___Divorced ___Widowed

Home Address _____

Home Phone # _____ Work Phone # _____ Other # _____

Employer _____ City _____ State _____

If you are a College Student: School _____ City _____ State _____

Spouse's Name _____ Employer _____ Is spouse a patient here? ___Yes ___No

Person to Contact in Case of an Emergency _____ Phone # _____

RESPONSIBLE PARTY INFORMATION

Name of Person Responsible for Account _____ Relation to Patient _____

Social Security # _____ Date of Birth _____ Employer _____

Home Address (If different than patient's) _____

Home Phone # _____ Work Phone # _____ Other # _____

DENTAL INSURANCE INFORMATION

Name of Primary Dental Insurance Company _____ Phone # _____

Subscriber's Name _____ Social Security # _____ Birthdate _____

Is this policy through the subscriber's employer? ___Yes ___ No If "Yes": Name of Employer _____

Group # _____ On what date did coverage become effective for the patient? _____

Yearly Deductible Amount $_____ Maximum Annual Benefit Amount $_____

Does patient have additional dental insurance coverage? ___Yes ___No (If "yes" , there is a separate form for secondary insurance)

SIGNATURE: As the party responsible for the patient named above, my signature indicates that I have completed this form (front and back), and all information that I have provided is accurate and complete to the best of my knowledge.

Signed: _____ Date: _____

(O V E R)

DENTAL HISTORY

Reason for Today's Visit _____

Date of Last Dental Visit _____ Dentist's Name _____ Location _____

Place a check mark by any of the following with which you (the patient) have, or have had problems:

___Bad Breath	___Chewing on One Side	___Lip or Cheek Biting
___Bleeding Gums	___Dry Mouth	___Loose Teeth
___Blisters or Sores on Lips	___Fingernail Biting	___Chipped Teeth/Broken Fillings
___Blisters or Sores in Mouth	___Biting Objects (Pens/Pencils)	___Mouth Breathing
___Clicking or Popping Jaw	___Food Collection Between Teeth	___Mouth Pain with Brushing
___Jaw Pain or Tiredness	___Grinding Teeth	___Periodontal Disease
___Burning Sensation on Tongue	___Gums Swollen or Tender	___Pain around Ear

Do you have braces? YES or NO

Place a mark by any of the following that cause tooth sensitivity or pain: ___Cold ___Heat ___Sweets ___Biting/Chewing

How often do you floss? _____ How often do you brush? _____

Place a mark by any of the following that you are unhappy with: ___Color of Teeth ___Straightness of Teeth ___Breath Odor

MEDICAL HISTORY

Physicians Name _____ Location _____ Date of Last Visit _____

Have you (the patient) ever had any serious illnesses or operations? __Yes __No If "Yes", describe: _____

Place a check mark by any of the following medical conditions that you (the patient) have, or have had a history of:

___Anemia	___Congenital Heart Defect	___High Blood Pressure	___Scarlet Fever
___Arthritis	___Cortisone Treatments	___HIV (AIDS)	___Shortness of Brea
___Artificial Heart Valve	___Cough, Persistent/Bloody	___Kidney Disease	___Sinus Trouble
___Artificial Joints	___Diabetes	___Liver Disease	___Skin Problems
___Asthma	___Emphysema	___Low Blood Pressure	___Stroke
___Back Problems	___Epilepsy	___Mitral Valve Prolapse	___Swelling (Feet/Ankles)
___Bleeding Abnormally	___Fainting or Dizziness	___Nervous Problems	___Swollen Neck Glands
___Blood Disease	___Glaucoma	___Pacemaker	___Thyroid Problems
___Cancer	___Headaches	___Psychiatric Care	___Tonsillitis
___Chemical Dependency	___Heart Murmur	___Radiation Treatment	___Tuberculosis
___Chemotherapy	___Heart Problems	___Respiratory Disease	___Ulcer
___Circulatory Problems	___Hepatitis, Type _____	___Rheumatic Fever	___Venereal Disease

Have you (the patient) ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ___Yes ___No

WOMEN: Are You Pregnant? ___Yes ___No Are You Nursing? ___Yes ___No Taking Birth Control Pills? ___Yes ___No

MEDICATIONS: List all medications you are currently taking: _____

_____

Have you ever been told to take antibiotics before dental treatment? YES or NO if "YES", reason:_____

Do you have your antibiotics? YES or NO ,if "YES" Name of Antibiotic, Dose and Instructions:_____

_____

ALLERGIES: Check if you are allergic: ___Penicillin ___Sulfa ___Latex ___Local Anesthetic ___Aspirin ___Codeine

___Other Allergies (Please List): _____