CLAIR R. VERNON, D.M.D. 271 South Main Street Tooele, Utah 84074 435-882-3700

PATIENT INFORMATION

In order to help us render the proper dental services to you, would you please be kind enough to answer the following questions. (Reverse side also) Thank you for your cooperation.

I. PERSONAL							
Patient's Name			Date				
Birth date	First	Middle	Age	Social Sec	curity No		
Mailing Address			reet or P.O. Box		Email		
Home Phone #	City	Ce		State	Zip code Work #		
Patient's Marital Status: Single		gle M	Married Divorced _		Widow	Separated	
Person Responsible	e For Account	:		Compl	ete Name		
Relationship to Patient			Social Se	curity Number	urity Number Date of Birth		
Employer	Occupation			tion	How Long		
Business Address					Phone #	Ext	
Spouse's Name		Social Security # Date of Birth				ate of Birth	
Spouse's Employer	r				Phone #	Ext	t
Nearest Adult Relative Not Living With You Relationship							
AddressWhom May We Th	ring Vou		Name	Phone #			
Whom Way We II	iank for Kelei	ing rou		V			
II. PRIMARY D Name of Insurar					Ef	fective Date	
Addmona				City	9:	tate Zip Co	nde.
Name of Insured _			G	roup #		Zip Co	
III. SECONDA	RY DENTA	L INSURA	NCE				
Name of Insurance				Effective Date			
Name of Insured _				City roup #		zate Zip Co	ode

MEDICAL HISTORY:

Physici	ian's Name:	Jacob Allin di Commencia di Commencia	Phone Number							
Please	answer the follow	ing questions as complete	ely as possible (circle/check	"Yes" or "No")						
			's care within the past year?	Yes _ No_						
1.		tion being treated								
2.	Do you take any med	dication, including birth cont	trol pills?	Yes No						
_,	Please specify name	and purpose of medications:	5555555 							
3.	Do you require antib	iotic pre-medication for a he	eart condition, artificial valve or	joint? Yes No						
4.	Do you have or have you ever had:									
	Rheumatic fever	Yes No	Venereal Disease	Yes _ No _						
	Heart Murmur	Yes No	Hepatitis	Yes _ No _						
	Heart Condition	Yes No	High Blood Pressure	Yes _ No _						
	Asthma	Yes No	Diabetes	Yes _ No _						
	AIDS	Yes No	Fen-Phen Diet Pills	Yes _ No _						
	HIV Positive	Yes _ No _	Abnormal bleeding	Yes _ No _						
	Any other problem o	or disease? Please specify								
5.			allergic to any of the following							
	Penicillin Latex	Aspirin Acetaminoph Metals Ba	en Ibuprofen Cod rbiturates Other	leine Sulfa Drugs						
6	Do you have any oth		ibiturates offici	Yes No						
0.	If yes, please describ			103 110						
7.	Are you allergic to a			Yes _ No _						
8.	Have you ever had a	severe reaction to dental trea	atment or local anesthetics?	Yes No						
9.	Have you ever receiv	ved counseling for excessive	use of alcohol and/or prescription	on drugs?						
		J	, ,	Yes No						
10.	WOMEN: Are you	pregnant? Yes No	If yes, when are you due?							
11.	How long ago did yo	ou last see a dentist?								
I here	eby certify that the	answers to the foregoing	questions are accurate to t	ne best of my ability						
Signat		, legal guardian or authorized agent of								
	\$1.0000000		## 1000 to 0.00							
Updat	e Signature		Date							
Updat	e Signature	Date								
Updat	e Signature	Date								
Updat	e Signature	Date								
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