JAMES M. BLAKE, D.D.S., PC

247 Buffalo Street Hamburg NY 14075 Phone: 648-2600 or 648-2765

PATIENT INFORMATION:

Date_____

In order to help us render the proper dental services to you, would you please be kind enough to answer the following questions. Please note the space for remarks that require clarification or any other information you think we should have. Thank you for your cooperation. This form and your dental records will be kept **STRICTLY CONFIDENTIAL**.

Name_____ Social Security Number_____

Home Phone_____ Work Phone_____ Cell Phone_____

_____

Home Address City State Zip Code

E-Mail Address_____

Date of Birth_____ Circle: Male Female Circle: Single Married Divorced Widow

Employer Name & Address:_____

Dental Insurance:_____ ID Number_____

_____

Insured: Name/Date of Birth Insured's Employer Group #

Responsible Party for Account:_____ Relationship to Patient_____

Closest Relative(Not living with you) Name & Phone Number:_____

Whom may we thank for referring you?_____

MEDICAL HEALTH:

General Health: Circle: Excellent Good Fair Poor

Name and Address of Physician:_____

Last Complete Physical:_____ Are you taking any medications now? Yes No

If so, list medications and reasons:_____

HAVE YOU EVER HAD:

Heart Disease……..Yes__ No__
Rheumatic Fever……Yes__ No__
Heart Murmur……Yes__ No__
Congenital Heart Lesions……Yes__No__
Abnormal Blood Pressure……...Yes__ No__
Stroke……..…Yes__ No__
Anemia……Yes__ No__
Ulcers……..Yes__ No__
Thyroid Disorders…….……..Yes__ No__
Epilepsy…….……Yes__ No__
Kidney Disorders……Yes__ No__
A.I.D.S. or HIV Positive.……Yes__ No__
Reactions to Local Anesthetics...Yes__ No__
(i.e. Novocain)

Mononucleosis……..Yes__ No__
Epstein Barr Virus……Yes__ No__
Asthma…….……..Yes__ No__
Sinus Trouble……Yes__ No__
Hay Fever…….……Yes__ No__
Jaundice……Yes__ No__
Tuberculosis or Lung Disease……Yes__ No__
Hepatitis……Yes__ No__
Arthritis……Yes__ No__
Glaucoma……Yes__ No__
Diabetes……..Yes__ No__
Mental or Nervous Disorders……Yes__ No__
Sexually Transmitted Diseases…..Yes__ No__
Implants/Artificial Body Parts…..Yes__ No__

PLEASE COMPLETE BOTH SIDES OF THIS FORM **OVER →**

Medical Health (continued)

Have you ever been treated for cancer or other types of tumors?……..Yes___No___

List any allergies:_____

Are you subject to prolonged bleeding?……Yes___No___
Are you subject to fainting spells?……..Yes___No___
Have you ever been hospitalized for any operations or serious illness?……Yes___No___

If so, please list:_____

_____

Do you have excessive urination and/or thirst?……..Yes___No___

Do you smoke or use tobacco?……Yes___No___ Frequency:_____

Do you drink alcoholic beverages?….Yes___No___ Frequency:_____

Are you pregnant?……Yes___No___ How Long?_____

Dental Health

Reason for today's visit_____

When was your last dental visit?_____

Have you ever had any serious problem associated with previous dental treatment?……Yes___No___

If so, please explain:_____

How often do you brush your teeth?_____Floss your teeth?_____

Do your gums bleed while brushing or flossing?……...Yes___No___

Do you clench or grind your teeth while sleeping or during the day?……Yes___No___

Please add anything you feel is important:_____

_____

To my knowledge I have given an accurate report of my physical and dental health history. I have also reported any allergic reactions to drugs, any blood, body, skin or gum diseases, abnormal bleeding or any other conditions related to my health. I understand that my failure to report accurate health information is dangerous to my health and well-being. I have reported any and all drugs or medications that I take and will advise the dentist of any changes in these or any changes in my health as soon as they occur. I give my consent for examination and treatment, including x-rays as deemed necessary by Dr. Blake or his associates.

_____
Patient Signature

_____
Signature of parent or guardian if patient is under 18 years old

_____
Relationship to patient

Our office policy is to accept payment at the time services are rendered, unless other arrangements are made with the office manager. We will complete your dental insurance forms as a courtesy to you. You are ultimately responsible for payment of all charges on this account, including interest as well as costs incurred for collections and any reasonable attorney fees. You will be responsible for a fee for broken appointments unless 24 hours notice is given.