HOLOHAN DENTAL PROFESSIONALS, P.C.

Welcome to Our Practice

Please complete and sign this confidential patient information form (both sides). Thank you!

Patient Name: _____(circle) Mr. Mrs. Ms. Dr. Rev.

I prefer to be addressed as: _____

Address: _____
Street Address City, St Zip

Telephone: Home: (____)_____ Work: (____)_____ Cell: (____)_____

Where and when is the best time to reach you? _____

(check one): ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Date of Birth _____/_____/_____ **SS#** _____-_____-_____
Mo Day Yr

Employer: _____ There for _____ yrs.

Employer Address: _____

Occupation: _____

Who may we thank for referring you? _____

Other family members seen by us?_____

Spouse's Name: _____(circle) Mr. Mrs. Dr. Rev.

Date of Birth: _____/_____/_____ **SS#** _____-_____-_____

Telephone: Work (____)_____ Cell (____)_____

Employer: _____ There for _____ yrs.

Employer Address: _____

Occupation: _____

Account Information (for insurance and payment purposes)

Dental Insurance Company _____

Name on Account: ☐ Self ☐ Spouse ☐ Other _____

Payment Plan Preferred: (please check one)

☐ Cash or personal check at time of treatment.

☐ Visa, MasterCard or Discover at time of treatment.

☐ I wish to establish credit with your office for personalized financial arrangements. I authorize a credit history report.

(turn over)

Medical History

My current medical health is: □ Excellent □ Good □ Fair □ Poor

Are you under the care of a physician? □ YES □ NO

Physician Name:_____

Office Location: _____

Office Telephone: _____

List all medications you take (prescription and over-the-counter):

_____

_____

Female Patients: □ Pregnant □ Nursing □ Using Birth Control _____(type)

Have you ever had any of the following:

□ Heart Attack □ Heart Surgery □ Mitral Valve Prolapse □ Heart Murmur

□ Pacemaker	□ Rheumatic Fever	□ Scarlet Fever	□ Hepatitis
□ Kidney Problems	□ Cancer	□ Chemotherapy	□ Radiation Treatment
□ HIV/Aids	□ Shingles	□ Artificial Joint	□ Artificial Valve
□ Fever Blisters	□ Cold Sores	□ Stroke	□ Sinus Trouble
□ Epilepsy/Seizures	□ Diabetes	□ Tuberculosis	□ Psychiatric Problems
□ Ulcers	□ Colitis	□ Anemia	□ Drug/Alcohol Dependence
□ Asthma	□ Arthritis	□ Emphysema	□ Hemophilia/Bleeding
□ Venereal Disease	□ Fainting	□ Glaucoma	□ Difficulty Breathing
□ High/Low Blood Pressure		□ Blood Transfusion	□ Headaches-severe/frequent

□ Hospitalized for _____

Allergies: Are you allergic or have you had difficulty with any of the following substances?

□ Penicillin □ Tetracycline □ Latex □ Aspirin □ Codeine □ Dental Anesthetic
□ Sulfa □ Erythromycin □ Other _____

Do you exercise regularly? □ YES □ NO

If YES, what do you enjoy doing? _____

The information I have provided is true to the best of my knowledge. I authorize the doctor to take X-rays, study models, photographs, or other diagnostic materials deemed appropriate by the doctor to make a thorough diagnosis of my dental health condition. I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the services required for my dental health. I understand that the doctor will discuss treatment before it is initiated. I further authorize and consent that the doctor choose and employ such assistance as deemed fit.

SIGNED: _____ **Date:** _____