

**Welcome**  
**C. Farrell Fruge', Jr. D.D.S.**

**Patient Information**

SS# \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Check Appropriate Box**

\_\_\_ Minor \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Separated Sex \_\_\_ F \_\_\_ M

Age \_\_\_\_\_  
Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

In Case of emergency who should we call? \_\_\_\_\_

**Responsible Party**

Person Responsible for account \_\_\_\_\_

Relation to Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS # \_\_\_\_\_

Address ( If other than Patient) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Address \_\_\_\_\_

Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_ Insurance Phone \_\_\_\_\_

**Additional Insurance**

Subscriber Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ Date of Birth \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Employed By \_\_\_\_\_ Business Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ SS# \_\_\_\_\_ Group # \_\_\_\_\_

## Medical History

**PLEASE CHECK IF YOUR MEDICAL HISTORY INCLUDES ANY OF THE FOLLOWING:**

1. Are you Anemic ? \_\_\_\_\_ yes \_\_\_ no \_\_\_
2. Are you a Diabetic ? \_\_\_\_\_ yes \_\_\_ no \_\_\_
3. Did you have Rheumatic Fever \_\_\_\_\_ yes \_\_\_ no \_\_\_
4. Do you have Heart Trouble \_\_\_\_\_ yes \_\_\_ no \_\_\_
5. Do you have High or Low Blood Pressure \_\_\_\_\_ yes \_\_\_ no \_\_\_
6. Do you have Hemophilia or any blood disorder ? \_\_\_\_\_ yes \_\_\_ no \_\_\_
7. Have you had Radiation Treatment ? \_\_\_\_\_ yes \_\_\_ no \_\_\_
8. Have you been diagnosed or exposed to HIV? \_\_\_\_\_ yes \_\_\_ no \_\_\_
9. History of liver problems or Hepatitis? \_\_\_\_\_ yes \_\_\_ no \_\_\_
10. Do you have Asthma? \_\_\_\_\_ yes \_\_\_ no \_\_\_
11. Do you have Kidney Problems? \_\_\_\_\_ yes \_\_\_ no \_\_\_
12. Do you suffer from Epilepsy ? \_\_\_\_\_ yes \_\_\_ no \_\_\_
13. Are you allergic to any Medicines ? \_\_\_\_\_ yes \_\_\_ no \_\_\_
14. Have you ever had a reaction to local or general anesthetic? \_\_\_\_\_ yes \_\_\_ no \_\_\_
15. Date of last dental appointment? \_\_\_\_\_ yes \_\_\_ no \_\_\_
16. Do your jaws ever make a cracking or popping noise? \_\_\_\_\_ yes \_\_\_ no \_\_\_
17. Do you grit, grind, or clench your teeth ? \_\_\_\_\_ yes \_\_\_ no \_\_\_
18. Do your gums bleed easily? \_\_\_\_\_ yes \_\_\_ no \_\_\_
19. Do you snore or have sleep apnea? \_\_\_\_\_ yes \_\_\_ no \_\_\_
20. Do you intend to schedule regular dental appointments ? \_\_\_\_\_ yes \_\_\_ no \_\_\_
21. Do you worry about having a fresh breath? \_\_\_\_\_ yes \_\_\_ no \_\_\_
22. Do you want whiter teeth? \_\_\_\_\_ yes \_\_\_ no \_\_\_
23. FEMALES: Are you pregnant ? \_\_\_\_\_ yes \_\_\_ no \_\_\_
24. Have you had a medical exam within the past twelve months ? \_\_\_\_\_ yes \_\_\_ no \_\_\_
25. Name and number of medical doctor \_\_\_\_\_ yes \_\_\_ no \_\_\_
26. List any pertinent information \_\_\_\_\_
27. List medications you are presently taking \_\_\_\_\_
28. List any Surgery you have had ? \_\_\_\_\_

I agree that the information provided by me is correct :

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_