



JAMES C. CALVIN, D.D.S., P.C.
STEPHEN K. CALENDINE, D.D.S.

Patients Information (PLEASE PRINT)

Date _____

Name _____ Phone _____

Address _____

City/State/Zip _____

Sex M F Age _____ Birthdate _____

Patients SS# _____ Single Married Widowed Divorced

Occupation _____

Employer _____

Employers Address _____

Employers Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____ Phone _____

Whom may we thank for referring you? _____

Best time and place to reach you _____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____ Group # _____

Is Patient covered by additional Insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Credit Card (Please provide at least one)

Acct. # _____

Name on Card _____

Exp. Date _____ Visa/Mastercard AMEX Discover

Dental History

Reason for today's visit _____

Date of last dental visit _____

	Yes	No		Yes	No
Burning sensation or tongue	<input type="checkbox"/>	<input type="checkbox"/>	Mouth Breathing	<input type="checkbox"/>	<input type="checkbox"/>
Chew on one side of mouth	<input type="checkbox"/>	<input type="checkbox"/>	Mouth pain, brushing	<input type="checkbox"/>	<input type="checkbox"/>
Cigarette, pipe or cigar smoking	<input type="checkbox"/>	<input type="checkbox"/>	Orthodontic Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Clicking or popping jaw	<input type="checkbox"/>	<input type="checkbox"/>	Pain around ear	<input type="checkbox"/>	<input type="checkbox"/>
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Peridental treatment	<input type="checkbox"/>	<input type="checkbox"/>
Loose teeth or broken fillings	<input type="checkbox"/>	<input type="checkbox"/>			

Health History

Physician's Name _____

Date of last visit _____

Please mark "Yes" or "No" to indicate if you have had any of the following:

	Yes	No		Yes	No
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis, Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valves	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints, Where _____	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding abnormally,	<input type="checkbox"/>	<input type="checkbox"/>	Women: Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
with extractions or surgery			Due date _____		
Blood disease	<input type="checkbox"/>	<input type="checkbox"/>	Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Lesions	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone Treatments	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Cough, persistent or bloody	<input type="checkbox"/>	<input type="checkbox"/>	Skin Rash	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Feet or Ankles	<input type="checkbox"/>	<input type="checkbox"/>
Fainting or dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Neck Glands	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Tumor or growth on head or neck?	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis, Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	STD	<input type="checkbox"/>	<input type="checkbox"/>
HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss, unexplained	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion, When _____	<input type="checkbox"/>	<input type="checkbox"/>

Medications

List medications you are currently taking:

Allergies

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Barbiturates (Sleeping pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Latex
<input type="checkbox"/> Other _____	

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household)

Name _____ Relationship _____

Home Phone _____ Work Phone _____

CONSENT: As the undersigned, I hereby authorize the Doctor to, after thorough explanation, take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a diagnosis of my dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated (after they are discussed with me) and further authorize and consent that the Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that it is my responsibility to understand the terms and limitations of my insurance. I also understand that responsibility for payment for Dental Services provided in this office for myself or my dependent is mine, due and payable at the time services are rendered.

SIGNATURE OF PATIENT, PARENT OR RESPONSIBLE PARTY

RELATIONSHIP TO PATIENT