Anne E. Newman DDS

Date: _____

PATIENT INFORMATION (Please Print) CONFIDENTIAL

Name_____ Birthdate_____

Address_____City_____State____Zip_____

Home phone #_____ Cell _____

Check Appropriate Answer: _ Married _ Single _ Widowed _Separated _Divorced

SS#_____ Employer _____

Occupation_____ Business Phone #_____

Spouse Information: Name:_____

Cell Phone #_____ Business Phone #_____

Person to contact in case of an emergency (if different from above):

Name:_____ Cell #_____ Work #_____

RESPONSIBLE PARTY (if other than yourself):

Name of person responsible for this account_____

Relationship_____ Address_____City_____State_____

Home Phone #_____ Business Phone#_____ Cell#_____

Social Security #_____Employer_____

DENTAL INSURANCE INFORMATION: Please Bring Your Card
Name of
Insured_____ Birthdate_____

Insurance Co._____ID#_____ Group#_____

Address_____City_____State_____ Zip_____

Phone #_____ Do you have additional dental insurance? _____

212 HIGHLAND AVENUE ROANOKE, VIRGINIA 24016 annenewmandds.com 540-344-6535 FAX: 540-345-6986

PATIENT MEDICAL HISTORY:

Physician_____ Phone_____

1. Are your under any medical treatment now? Yes___ No___
2. Have you ever been hospitalized? Yes___ No___
3. Are you taking any medications? Yes___ No___
   If yes please list medication name and dosage:
   _____
   _____
   _____
4. Do you wear contact lenses? Yes___ No___
5. Are you allergic to or have you ever had any reactions to the following:
   __Aspirin __Sulfa __Latex __Penicillin __Codeine
   __Anesthetics __Metals __Any Antibiotics __Other_____

PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING:

_Abnormal Bleeding
_Acid Reflux
_Alcohol Abuse
_Allergies
_Anemia
_Angina Pectors
_Arthritis
_Artificial Heart Valve
_Artificial Joints
_Asthma
_Blood Transfusion
_Cancer
_Chemotherapy
_Cholesterol Problems
_Colitis
_Congenital Heart Defect
_Diabetes
_Emphysema
_Epilepsy
_Fever Blisters
_Fibromyalgia
_Frequent Headaches
_Glaucoma
_HIV / AIDS
_Hay Fever
_Heart Attack
_Heart Murmur
_Heart Surgery
_Hemophilia
_Hepatitis A, B, or C
_High Blood Pressure
_IBS
_Kidney Problems
_Liver Disease
_Low Blood Pressure
_MS
_Mitral Valve Prolapse
_Pace Maker
_Psychiatric Problems
_Radiation Therapy
_Rheumatic Fever
_Seizures
_Shingles
_Shortness of Breath
_Sinus Problems
_Stroke
_Substance Abuse
_Thyroid Problems
_Tobacco Use
_Tuberculosis
_Ulcers
_Venereal Disease

Any other medical concerns? _____
_____
_____

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. BY SIGNING I ACCEPT RESPONSIBILITY FOR THIS ACCOUNT.

_____

PATIENT, PARENT, OR GUARDIAN