DARREN C. NORBY, DMD **8400 OSUNA, NE, SUITE 1C**
PHONE 505-296-1332 **ALBUQUERQUE, NM 87111**

PATIENT INFORMATION

Date: _____

Last Name:_____ First Name:_____ Middle Initial:___

Male___ Female ___Married ___Single___ DOB _____Social Security#_____

Phone (Home): _____ (Work):_____Ext._____ (Cell):_____

Street Address: _____Apartment #:_____

City: _____State:_____ Zip Code: _____

Occupation: _____ Employer:_____

Person to contact in case of an emergency: _____
Name Relationship

Emergency Contact's Phone Number: _____

Whom may we thank for referring you to our office? _____

Physician's Name: _____ Phone Number: _____

If you are filling out this form for another person, what is your relationship to this person? _____

Please explain why you have come to our office: _____

_____

_____

Insurance Information

Subscriber Name: _____DOB_____

Subscriber SS#:_____Group#:_____Policy#:_____

Employer: _____

Insurance Company Name_____

Insurance Company Address: _____

_____

This office does not have a contract with your insurance company. Patients who have dental insurance should remember that professional services are rendered to you, the patient, and not to the insurance company. You are financially responsible for all charges. By signing below, you authorize release of information relating to insurance claims and authorize payment to the dentist of the insurance benefits otherwise payable to you. If your account becomes delinquent, you will be responsible for the balance due, interest and collection costs.

Signature_____ Date_____

MEDICAL HISTORY

Are you presently under medical care? …….. YES NO
Explain_____
Have you been treated by a physician within the last 12months ……YES NO
Explain_____
Have you ever had a major operation? ……YES NO
Explain_____
Have you had a serious illness or injury? ……YES NO
Explain_____
Are you presently taking any medications or drugs? …… YES NO
Explain_____
Are you ALLERGIC to any medicine, drug, food, metal or latex gloves? ……..YES NO
Explain_____
Have you had adverse reactions to local anesthetics? ……..YES NO
Explain_____
Have you ever had problems with dental treatment or prolonged bleeding after tooth extractions? YES NO
Explain_____
Are you pregnant or suspect pregnancy? ……. YES NO

Read the medical conditions below. CIRCLE those that you have now and those you have had in the past.

Heart disease or heart murmur	Lung problems or emphysema
Heart attack	Tuberculosis
Mitral valve prolapse	Asthma or sinusitis
Rheumatic fever	Arthritis or painful joints
High blood pressure	Kidney disease
Low blood pressure	Intestinal or stomach problems
Fainting spells or seizures	Mental health problems
Artificial joints	Artificial heart valve
Vascular grafts	Chest pain
Cancer treatment (x-ray/medication)	Heart pacemaker
Sexually transmitted disease	Thyroid problems
Hepatitis or liver disease	Neurological disorder
HIV or AIDS	Bleeding or blood problems
Stroke	Anemia
Leukemia	Diabetes
Drug addiction	Jaw joint click, pop or painful

Any other problem not listed above:_____
_____

I certify that I have read and understand the above, and that my answers are truthful to the best of my knowledge. My questions concerning the above have been answered to my satisfaction.

Patient Signature _____ Date_____

FOR OFFICE USE ONLY:

PULSE_____ BLOOD PRESSURE_____