PLEASE PRINT CLEARLY

PATIENT INFORMATION
MICHAEL S. HAUSER, D.M.D., M.D.

Mr. Mrs. Ms. Dr.

Name of Patient: _____ Today's Date: _____

Date of Birth: _____ Age: _____ M/F SS#: _____

Address: _____

City/State: _____ Zip Code: _____

Home Phone #: _____ Bus. Phone #: _____ Ext. _____ Cell #: _____

Employer: _____ Address: _____

If a Minor: Name of Father: _____ Name of Mother: _____

Name of Spouse: _____ Date of Birth: _____ SS#: _____

Physician: _____ Address: _____ Phone: _____

Dentist: _____ Address: _____ Phone: _____

Referred By: _____ Address: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Responsible Person: _____ Address: _____ Phone: _____

PRIMARY MEDICAL INSURANCE:

Insurance Company: _____ Subscriber's Name: _____

Insurance Co. Address: _____

SS#: _____ Group Policy #: _____ Date of Birth: _____

Subscriber's Employer: _____ Address: _____ Phone: _____

SECONDARY MEDICAL INSURANCE:

Insurance Company: _____ Subscriber's Name: _____

Insurance Co. Address: _____

SS#: _____ Group Policy #: _____ Date of Birth: _____

Subscriber's Employer: _____ Address: _____ Phone: _____

PRIMARY DENTAL INSURANCE:

Insurance Company: _____ Subscriber's Name: _____

Insurance Co. Address: _____

SS#: _____ Group Policy #: _____ Date of Birth: _____

Subscriber's Employer: _____ Address: _____ Phone: _____

SECONDARY DENTAL INSURANCE:

Insurance Company: _____ Subscriber's Name: _____

Insurance Co. Address: _____

SS#: _____ Group Policy #: _____ Date of Birth: _____

Subscriber's Employer: _____ Address: _____ Phone: _____

I authorize use of my Protected Health Information (PHI) to carry out treatment, payment and health care operations; contact my house or other designated location and leave messages to assist in providing care, send information and statements to my home or designated address; share necessary PHI with other healthcare providers associated with my treatment. I understand I have the right to review Dr. Hauser's Privacy Statement. I understand I have the right to revoke my consent in writing except for disclosures already made prior to the office receiving such notice. I understand that Dr. Hauser has the right to refuse treatment if consent is not given.

_____ _____

(Signature of responsible party) (Date)

PLEASE PRINT CLEARLY

MEDICAL HISTORY
MICHAEL S. HAUSER, D.M.D., M.D.

Name of Patient: _____

What is your chief reason for this visit? _____

_____

Have you been treated for this condition previously? _____

Do you have other related concerns? _____

_____

GENERAL HEALTH: excellent: _____ good: _____ fair: _____ poor: _____
weight: _____ height: _____ blood pressure: _____

Do you smoke? Yes_____ No_____
Do you use alcohol daily? Yes_____ No_____
If female, are you pregnant? Yes_____ No_____ How long? _____
When was your last complete physical examination? _____

What conditions are you under treatment for now? _____

_____

Past surgeries or hospitalizations? Yes_____ No_____ When? _____

_____

DID YOU EVER HAVE: **(Please Circle all that apply)**

ASTHMA
CHRONIC BRONCHITIS
EMPHYSEMA
TUBERCULOSIS
HEART MURMUR
HIGH BLOOD PRESSURE
HEART ATTACK
HEART TROUBLE
FAINTING
KIDNEY DISEASE
DIABETES
RHEUMATIC FEVER
HEPATITIS
BLEEDING DISORDERS
LIVER DISEASE
INTESTINAL DISEASE
DRUG DEPENDENCY
RHEUM. ARTHRITIS
THYROID DISEASE
EPILEPSY
PSYCH. CONDITION
STROKE
VENEREAL DISEASE
CANCER
IMMUNE SYSTEM DISORDER

OTHER, GIVE ILLNESS: _____

_____

_____

List medications you are taking, include dosage and frequency: _____

_____

_____

ARE YOU ALLERGIC TO: Penicillin_____ Anesthesia_____ Novocaine _____Codeine_____

Other: Specify: _____