Welcome to

MarrFamilyDentistry

Kevin Marr D.D.S. Kami Marr D.D.S.

Patient's Name:_____Age____Birthdate_____SS#_____
Home Phone_____Cell_____Work_____Email Address_____
Residence Address_____City_____ST_____Zip_____
Billing Address_____ City_____ST_____Zip_____
Occupation_____ Employer_____Address_____
Spouse's or, if Minor, Parent's Name_____Address_____
Responsible Party's Address_____
Responsible Party's Home Phone_____Work_____Cell_____
Responsible Party's Place of Employment_____
Insurance Company_____ID #_____
Policy Holder_____Social Security #_____
Policy Holder's Birthdate_____Employer's Address_____

Confidential Medical History

1. Regular Physician's Name_____
2. Have you been under the care of a medical doctor during the past five years? Yes / No
   If yes, for what? _____
   Have you been hospitalized in the past five years? Yes / No
   If yes, for what? _____
3. Are you taking any medication, drugs or pills now? (Include over-the-counter, vitamins, etc.) Yes / No
   If yes, please list name and dosage:_____
   _____
4. Are you allergic to anything? (Medications, Metals, or other substances) Yes / No
   If yes, please list: _____
   _____
5. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item

High Blood Pressure……..	Yes / No	Cancer / Tumors …….....	Yes / No
Heart surgery, disease, attack…….	Yes / No	Cancer /Radiation Therapy…….....	Yes / No
Congenital Heart defects……	Yes / No	Cancer / Chemotherapy……	Yes / No
Heart Murmur……..	Yes / No	Alcoholism ……	Yes/No
Artificial Heart Valve……..	Yes / No	Hepatitis, if yes, which type_____.....	Yes / No
Heart Pacemaker……	Yes / No	Venereal Disease ……...	Yes / No
Arthritis …….	Yes / No	AIDS ……...	Yes / No
Stroke …….	Yes / No	HIV Positive ……	Yes / No
Artificial Joints(hip, knee, etc)……	Yes / No	Blood Transfusion ……	Yes / No
Dialysis ……..	Yes / No	Hemophilia ……	Yes / No
Kidney trouble……	Yes / No	Cold Sores ……	Yes / No
Anemia ……	Yes / No	Liver Disease ……	Yes / No
Organ Transplant……	Yes / No	Neurological Disorders……...	Yes / No
Ulcers ……	Yes / No	Psychiatric Care ……..	Yes / No
Diabetes ……	Yes / No	Epilepsy / Seizures ……..	Yes / No
Emphysema……	Yes / No	Fainting/ Dizzy spells ……..	Yes / No
Tuberculosis……	Yes / No	Drug Addiction ……..	Yes / No
Asthma …….	Yes / No	Latex Sensitivity ……..	Yes / No

6. If you have a disease, condition or problem not addressed above, please list. _____
   _____
7. Have you ever had excessive bleeding? Yes / No
8. Do you smoke or chew tobacco? If yes circle type, how long? _____ Yes / No
9. For Women - Are you: Pregnant? Yes/ No Nursing? Yes / No Taking Birth Control pills? Yes / No
10. Is there any other information that we should know about your health? Please specify_____
    _____