Frank L. Conaway Jr, DMD, PC
292 Hancock Square
Bay St. Louis, MS 39520 (228)467-4670

Patient Name_____

Birthdate_____ SS#_____ Sex_____

Residence_____

Home Phone_____ Work Phone_____ Cell Phone_____

How Did You Hear About Us (Internet, Individual (please provide name), Ad)?_____

Your Employer_____

Occupation_____ How Long?_____

Spouse's Name_____ Work Phone_____

Spouse's Employer_____ Occupation_____

Spouse's Birthdate_____ SS#__ _____

Person Responsible For Account_____ Relation_____

Mailing Address_____

How Long At This Address_____ Email Address _____

Dental Insurance Co._____ Phone # _____

Group Number _____ Member ID Number _____

Insured's Name_____ _____ Relation_____

In The Event Of An Emergency Whom Should We Contact_____

Complete Address_____

Home Phone_____ Cell Phone_____ Relation_____

Reason For Today's Visit *Exam* *Emergency* *Consultation* Are You In Pain?_____

Please Indicate The Following Problems:

Discomfort, clicking/popping in jaw	Y N	Lost/broken fillings	Y N
Stained teeth	Y N	Red, swollen or bleeding gums	Y N
Teeth grinding/clenching	Y N	Locking jaw	Y N
Sensitive teeth or gums	Y N	Bad breath	Y N
Blisters/sores in or around mouth	Y N	Broken/chipped teeth	Y N

Previous Dentist_____ Last Dental Exam_____

How Often Do You Brush_____ How Often Do You Floss_____ Brush Is *Soft* *Medium* *Hard*

Over Please

Your Health Is *Excellent* *Good* *Fair* *Poor* Are You Under A Physician's Care_____

Physician's Name_____ Phone Number_____

Are You Taking Any Medications: Y N *Please List* _____

_____

Do You Have Or Have You Had Any Of The Following (***Please Circle Each One "Y" Yes or "N" No)***:

Heart Attack/Disease	Y N	Frequent Neck Pain	Y N	Cosmetic Surgery	Y N
Heart Failure	Y N	Emphysema	Y N	HIV/AIDS	Y N
Chest Pains	Y N	Tuberculosis (TB)	Y N	Hepatitis A	Y N
High Blood Pressure	Y N	Chronic Bronchitis	Y N	Hepatitis B	Y N
Low Blood Pressure	Y N	Persistent Cough	Y N	Hepatitis C	Y N
Heart Murmur	Y N	Asthma	Y N	Liver Problems	Y N
Rheumatic Fever	Y N	Sinus Problems	Y N	Yellow Jaundice	Y N
Congenital Heart Defect	Y N	Hay Fever	Y N	Blood Transfusion	Y N
Scarlet Fever	Y N	Allergies/Hives	Y N	Drug or Alcohol Abuse	Y N
Artificial Heart Valve	Y N	Diabetes	Y N	Venereal Disease	Y N
Mitral Valve Prolapse	Y N	Thyroid Problems	Y N	Hemophilia	Y N
Heart Pacemaker	Y N	X-ray/Cobalt Treatment	Y N	Genital Herpes	Y N
Heart Surgery	Y N	Chemotherapy (Cancer)	Y N	Epilepsy/Seizures	Y N
Artificial Joints/Bones	Y N	Arthritis/Rheumatism	Y N	Fainting/Dizziness	Y N
Anemia	Y N	Cortisone Medicine	Y N	Psychiatric Treatment	Y N
Stroke	Y N	Glaucoma	Y N	Sickle Cell Disease	Y N
Kidney Problems	Y N	Pain In Jaw Joints	Y N	Bleeding Problems	Y N
Ulcer/Stomach Problems	Y N	Respiratory Problems	Y N	Frequent Headaches	Y N
Nervousness	Y N	Leukemia	Y N	Back Problems	Y N

Have You Been Advised To Take An Antibiotic Before Dental Treatment Due To A Medical Condition? Y N
Are You Allergic To Any Medication, Food, Latex Or Other?_____
Is There Any Other Condition Concerning Your Health?_____
(WOMEN) Are You Pregnant?_____ Are You Taking Birth Control Or Hormone Therapy?_____
Do You Now or Have You In The Past Taken Medication for Osteoporosis?_____

Our dental office sends appointment reminders, info about treatment, payment, insurance, and other communications. Please tell us how you would like us to communicate with you. **Check all that apply.**

- o Call me
- o Text me
- o Email me

By signing below, you give consent to our office to contact you using the method(s) you have indicated. (Please note that if you choose to be contacted electronically for upcoming appointments, you will receive multiple reminders).

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between Dr. Conaway and the patient.
- By signing below you authorize Dr. Conaway to perform any necessary services needed during diagnosis and treatment.
- Please be advised due to our insurance liability, all patient records must remain with the office. However, for a nominal fee, copies of records may be forwarded upon request.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient Signature _____ Date_____