James Case D.D.S.
Anuya Diwan B.D.S.
3006 N. County Rd. 25-A Suite 202
Troy, Oh 45373

Full Name ______________________________ Birth Date_________ Marital Status_______________
Home Address____________________________ Home Phone__________ Cell Phone_______________
City______________ State/Zip__________ Parents Name (if under 18) _______________________
Email________________________________ Occupation________________________________
Employer_______________ Social Security No.______________
Business Address_________________________ Zip__________ Work Phone____________________
Name of Insurance Holder______________Date of Birth (Ins. Holder)_________ Employer______________
Dental Insurance______________________ Group #____________ ID# or SS#__________________
Referred By_______________________________ Previous Dentist______________
Date of most recent cleaning with previous dentist______________________
Name of Physician________________________ Phone No. _________________________
In Case of Emergency Contact_______________________ Phone No.______________________

Medical History

Although dental personal primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

List Medications & Herbs

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1. Have you ever been hospitalized, major operations, or serious illness
   If so for what______________________
2. Are you under any medical treatment now? **YES / NO**
3. Have you had an allergic reaction to Novocain, aspirin, latex, or medication? **YES / NO**
   If so what______________________
4. Has there been a change in your health in the last year? **YES / NO**
5. Have you ever had a blood transfusion? **YES / NO**
6. Have you ever had a kidney dialysis treatment? **YES / NO**
7. Have you ever had abnormal bleeding problems after a cut or tooth extraction? **YES / NO**
8. Have you ever fainted? **YES / NO**
9. Do you use tobacco products? **YES / NO**
10. Do you have anything artificial in your body? **YES / NO**
11. Do you have a history of drug abuse? **YES / NO**

12. Has a physician ever informed you that you have:

Heart Ailment	Yes / No	AIDS	Yes / No	Respiratory Disease	Yes / No
Heart Murmur	Yes / No	Mitral Valve Prolapse	Yes / No	Blood Disease	Yes / No
Venereal Disease	Yes / No	G.I. Disease	Yes / No	Epilepsy	Yes / No
Kidney Disease	Yes / No	Hepatitis	Yes / No	Asthma	Yes / No
Diabetes	Yes / No	High Blood Pressure	Yes / No	Tumors / Growth	Yes / No
Angina	Yes / No	Stroke	Yes / No	Thyroid Problem	Yes / No

12. Women are you pregnant __________ If so expected due date____________

Authorizations

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services that I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover. * I understand that if I cancel an appointment and give less then 24 hour notice I will be charged a fee of $35.00

Signature Date

Date: _____ Pt. Initials___________ Staff:________ / Date: ______ Pt. Initials______ Staff:_________