Shane Samy, D.M.D., P.C.
2233 Willamette Street, Building #D
Eugene, Oregon 97405

PATIENT INFORMATION

In order to better help us serve and give you our recommendations, completion of this information in its entirety is requested at time of first visit. Please either check or circle responses appropriately **Y** (yes) **N** (no) or **N/A** (not applicable)

Name_____ Date:_____
Last First Middle/Preferred

Male____ Female_____ Single____Married____Child_____ Birthdate _____

Home Address_____ _____ _____
Street City State Zip Code

Home Phone (_____) _____-_____ Work Phone (____) _____-_____ Cell Phone (____) _____-_____

May we leave a message? Yes / No Preferred contact method: E-mail ____ Text____ Phone_____ home, work, cell
Circle preferred

Social Security #: _____ E-mail Address:_____

Employer_____ Occupation_____

Employer Address_____ _____ _____Work Phone (____)_____-_____
Street City State Zip Code

Spouse/Parent_____ Social Security # _____-_____-_____ Telephone (_____) _____-_____

Spouse Employer_____ Address_____Work Phone(_____) _____-_____

Responsible Party information

(If someone other than patient; May we discuss your treatment and financial arrangements w/ this individual? Yes / No)

Name of the responsible party_____

Birthdate_____ Male____ Female _____ Single____Married____Child____Other_____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____ Cell Phone (_____)_____-_____

Home Address_____ _____ _____
Street City State Zip Code

Employer_____Address_____

In case of EMERGENCY:
Relative to contact (other than spouse)_____ Phone (_____) _____-_____
Other person to contact (not relative)_____ Phone (_____) _____-_____

Form of payment? Cash____ Check____Credit Card____Insurance____Other_____

Primary Insurance Co._____Address_____ Phone (_____) _____-_____
Name of Insured_____ Policy #_____ Group # _____ _____

Secondary Insurance Co._____Address_____ Phone (_____) _____-_____
Name of Insured_____Policy #_____ Group #_____ _____

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this, or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees.
I hereby authorize the doctor to release information necessary to secure payment of benefits.

Signature_____ ***Date***_____ _

Medical History

Do you have a personal physician? ___ No___ Yes
Physician's Name_____
Phone #_____ Date of last visit_____
_____

Other Physicians:_____

Are you currently under the care of a physician for an active medical problem?
____No____Yes Please explain_____

Are you taking any prescription or over-the-counter drugs?
___No ___Yes If yes, please list each one:

Name of Drug	How much (mg)	How often (frequency)	Reason for taking medication
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

For Women:
Are you taking birth control pills? __No__Yes
(birth control pills can be inactivated by antibiotics)
Are you pregnant? ___No ___Yes Week #____
Are you nursing? ___No ___Yes

DO YOU PRESENTLY HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?
WHAT YEAR?

1. **Y N Heart Attack / Stroke**
2. **Y N Heart Murmur**
3. **Y N Heart Surgery**
4. **Y N Artificial Heart Valves**
5. **Y N Mitral Valve Prolapse**
6. **Y N Congenital Heart Defect**
7. **Y N Irregular Heart Beat or Pacemaker**
8. **Y N Chest Pain (Angina)**
9. **Y N High / Low Blood Pressure**
10. **Y N Rheumatic Fever/ Rheumatic Heart Disease**
11. **Y N Scarlet Fever**
12. **Y N Artificial Joints / Bones**
13. **Y N Cancer/ Chemotherapy / Radiation Therapy**
14. **Y N Taken any Bisphosphonates**
15. **Y N Thyroid / Low or High Hormone Level**
16. **Y N Cortisone Medication or ACTH Treatment**
17. **Y N Epilepsy / Seizures / Fainting Spells**
18. **Y N Hemophilia / Anemia**
19. **Y N Coagulation Problems / Excessive Bleeding**
20. **Y N Diabetes / Low or High Blood Sugar**
21. **Y N Ulcers / Colitis / Stomach Problems**
22. **Y N Arthritis / Rheumatism**
23. **Y N Tuberculosis**
24. **Y N Difficulty Breathing / Asthma / Emphysema**
25. **Y N Sinus Problems/Hay Fever**
26. **Y N Cold Sores / Fever Blisters**
27. **Y N Shingles**
28. **Y N Kidney Problems**
29. **Y N Hepatitis / Jaundice / Liver Disease**
30. **Y N Blood Transfusion**
31. **Y N Glaucoma / Eye Disorders**
32. **Y N Severe / Frequent Headaches**
33. **Y N Psychiatric Problems**
34. **Y N Swollen Ankles**
35. **Y N Drug / Alcohol Addiction / Recreational Drugs**
36. **Y N Venereal Disease / Herpes / Syphillis / Gonorrhea**
37. **Y N Genetic / Congenital / Family Type Disorders**
38. **Y N Recent Hospitalization**
39. **Y N HIV / AIDS**

Please list / describe any other serious medical condition(s) not listed above:
_____

Do you smoke or use tobacco in any form (chew, snuff)?
___N ___Y If yes, how many packs a day / how long?_____
Do you use alcoholic beverages? ___N ___Y
If yes, how many drinks per week?_____

Are you allergic to any of the following?

Y N Penicillin	**Y N Clindamycin**	**Y N Aspirin**
Y N Amoxicillin	**Y N Dental Anesthetics**	**Y N Codiene**
Y N Erythromycin	**Y N Oxycodone**	**Y N Sulfa**
Y N Metals	**Y N Latex Rubber**	**Y N Jewelry**
Y N Tetracycline	**Y N Plastic / Acrylic**	**Y N Other**

Please list any other allergies:_____

Do you need to be premedicated before dental treatment?
No Yes Don't know

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

I authorize the dental staff to perform diagnostic procedures and treatment as may be necessary for proper dental care.

Signature_____
Patient or Guardian

_____
Relationship to patient

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

--OFFICE USE ONLY--
I verbally reviewed the medical/dental information above with the patient named herein. Initials_____Date_____
Doctor's Comments / Signature_____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the C.D.C., and the ADA.