MICHAEL K. DEENIHAN, D. D. S.
FAMILY AND COSMETIC DENTISTRY

Name _____ Birthdate_____
Residence_____ Phone _____
City _____ State _____ Zip_____ Cell _____
Social Security Number _____
Occupation _____ Employer _____
Business Address _____ Phone _____
Marital Status _____ Spouse's Name _____
Spouse's Occupation _____ Employer _____
Business Address _____
Dental Insurance_____ Primary Carrier _____ Group #_____
Secondary Carrier _____ Group #_____
Billing Name _____
Physician's Name _____ Approximate Date of Last Physical _____
Who referred you to our office? _____

Medical History: *Have you ever experienced problems with:*

	yes	no		yes	no
Heart Disease	☐	☐	Aids	☐	☐
Rheumatic Fever	☐	☐	Anemia	☐	☐
Murmurs	☐	☐	Epilepsy	☐	☐
Mitral Valve Prolapse	☐	☐	Prolonged Bleeding	☐	☐
High Blood Pressure	☐	☐	Fainting Spells	☐	☐
Hepatitis, Liver Disease	☐	☐	Allergies to any drugs	☐	☐
Diabetes	☐	☐	Cancer	☐	☐
Orthopedic Joint Replacement	☐	☐	Kidney Disease	☐	☐
			Previous Dental Care	☐	☐

Have you been hospitalized in the last two years? _____
Are you currently taking any medications? _____
(Women) Are you now pregnant or nursing? _____

To the best of my knowledge the above information is true.

_____
signature/date

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