Robert W. Nunn, D.D.S.
3050 S. National Avenue, Suite 105
Springfield, MO 65804
(417) 887-8801

PERSONAL INFORMATION

Name____Date of Birth_______________

Address____Sex_____________

City_______________________________________State_______________Zip_____________

Home Phone______________________Marital Status _____________S.S.#___________________

Cell Phone_______________________________ Work Phone_____________________________

E-Mail ___________________________________ Employed By__________________________

Spouse or Parent:

Name____Date of Birth_______________

Address____

City_______________________________________State_______________Zip_____________

Home Phone_________________________________Cell Phone__________________________

Employed By______________________________ SS#________________________________

DENTAL INSURANCE INFORMATION

Do you have Dental Insurance? ....yes/no
If yes, please provide insurance card.
Insurance Company_________________________Insurance Phone #_____________________

PERSON RESPONSIBLE FOR THIS ACCOUNT:

Name___________________________________Phone_________________________________

Address____

PERSON TO CONTACT IN CASE OF EMERGENCY:

Name___________________________________Phone_________________________________

Referred By____

Over

Medical History

1) Are you having pain or discomfort at this time?..yes/no

2) Have you had any difficulty with tooth extractions?..yes/no

3) Physician's Name________________________________ Phone # ___________________________

4) Do you have latex allergy?..yes/no

5) Are you allergic or have you reacted adversely to any of the following medications? Please circle:

Aspirin	Nitrous Oxide	Valium	(Novacaine or Xylocaine)
Darvon	Erthromycin	Local Anesthetic	Tylenol
Codeine	Tetracycline	Penicillin	Acetaminophen
Demerol	Percodan	Other Antibiotics	Sulfa drugs

6) Are you aware of being allergic to any other medication or substance?..................................yes/no
If yes, please list____

Check the following which you have had or have at present:

Yes	No		Yes	No		Yes	No	
☐	☐	Heart Failure or Attack	☐	☐	Breathing problems	☐	☐	Liver Disease
☐	☐	Heart Disorder or Trouble	☐	☐	Tuberculosis	☐	☐	Yellow Jaundice
☐	☐	Angina Pectoris, chest pains	☐	☐	Asthma	☐	☐	Lung Disease
☐	☐	High Blood Pressure	☐	☐	Hay Fever	☐	☐	Blood Transfusion
☐	☐	Prolapsed Mitral Valve	☐	☐	Sinus Trouble	☐	☐	Drug Addiction
☐	☐	Heart Murmur	☐	☐	Allergies or Hives	☐	☐	Hemophilia
☐	☐	Rheumatic Fever	☐	☐	Diabetes	☐	☐	Venereal Disease (Syphilis, Gonorrhea)
☐	☐	Congenital Heart Disorders	☐	☐	Thyroid Disease	☐	☐	Aids, HIV+
☐	☐	Scarlet Fever	☐	☐	Radiation Treatment	☐	☐	Cold Sores/Fever Blisters
☐	☐	Artificial Heart Valve	☐	☐	Chemotherapy	☐	☐	Epilepsy or Seizures
☐	☐	Heart Pacemaker	☐	☐	Cancer, Leukemia	☐	☐	Fainting or Dizzy Spells
☐	☐	Heart Surgery	☐	☐	Arthritis	☐	☐	Nervousness, Emotional Problems
☐	☐	Artificial Joint	☐	☐	Rheumatism	☐	☐	Anemia
☐	☐	Cortisone Medicine	☐	☐	Psychiatric Treatment	☐	☐	Sickle Cell Disease
☐	☐	Stroke	☐	☐	Glaucoma	☐	☐	Bruise Easily
☐	☐	Kidney Trouble	☐	☐	Pain in Jaw Joints (TMJ)	☐	☐	Stomach or Bowel Trouble
☐	☐	Ulcers	☐	☐	Hepatitis A	☐	☐	Skin Disease
☐	☐	Emphysema	☐	☐	Hepatitis B	☐	☐	Bleeding Problems
☐	☐	Cough (frequent)	☐	☐	Hepatitis C			

7) Do you use more than 2 pillows to sleep?..yes/no
8) Are you on a special diet?...yes/no
9) Has your medical doctor ever said you have a cancer or tumor?..................................yes/no
10) Do you have any disease, condition or problem not listed?..yes/no
11) Do you drink alcohol, beer?..yes/no
12) Do you smoke?...yes/no
13) Do you use any tobacco products?...yes/no

FOR WOMEN ONLY:
Are you pregnant? Yes __ No___ If yes, what month? _______ Are you taking birth control pills? Yes____No____

CONSENT: To the best of my knowledge, the above is complete and correct. The undersigned hereby authorizes Doctor to take radiographs, Study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with(name of patient)____________________and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I authorize the release of any needed medical or dental information necessary to the care of Robert W. Nunn D.D.S. I understand that responsibility for payment of Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a 1 ½% finance charge (18% annually) will be added to any balance over 60 days. In the event of default, I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. By signing below I give authorization to this office to contact me by home phone, cell phone, work phone, and e-mail address that I choose to provide.

PATIENT____ Date____________________