Barney E. Selph, D.D.S., Ltd.

726 Randolph Avenue
P.O. Box 88
Cape Charles, Virginia 23310

Patient Information

Date_____
Name_____ Nickname_____ Birthdate_____
911 Address_____ Zip_____ Home Phone_____
Mailing Address_____ Zip_____
Employer_____ Address_____ Work Phone_____
Social Security #_____ Sex: __M __F Marital Status_____
Spouse's Name_____ Birthdate_____ __M __F
Employer_____ Social Security #_____
Business Address_____
Phone_____

Whom may we Thank for referring you?_____

Person Responsible for Account __Self __Spouse __Parent or Guardian __Other Social Security #_____
Name(Responsible Party)_____ Birthdate_____ Sex: M___ F___
Address(If Different)_____ Zip_____ Home Phone_____
Employer_____ Address_____ Work Phone_____
In Case of Emergency, name of the nearest relative not living with you?_____
Phone #_____ Address_____

Are any of your family members patients here? __Yes __No If so, who?_____

Medical History

Physician's Name_____ Phone #_____
Address_____ Date of Last Physical _____
Are you taking any Medication? __Yes __No Please List 1._____ 2._____ 3._____
4._____ 5._____ 6._____
Are you allergic to: Penicillin __Y __N Codeine __Y __N Novacaine __Y __N Other Medications __Y __N

Please Check all that Apply

Prolonged Bleeding ___
High Blood Pressure ___
Heart Murmur ___
Blood Transfusion ___
Heart Trouble ___
Ulcers ___
Diabetes ___

Rhuematic Fever ___
Are You Pregnant? __
Allergies ___
Epilepsy ___
Arthritis ___
Hepatitis ___
Tuberculosis ___

Glaoma ___
Sinus Trouble ___
Joint Replacements __
Heart Surgery ___
Stroke ___
AIDS or HIV Positive ___
Major Surgery ___

Would you like to have your blood pressure recorded? __Y __N Any reactions to drugs or anesthetics? __Y __N
Any other information about your health we should know?_____

(MORE ON THE BACK)