Peter M. Tufton D.D.S.
(504-362-5270)

Patient Name: ________________________________ Date of Birth: _____________ Today's Date: ______________________

Gender: male__ female__ Status: married__ single__ child__ widow__ Social Security #:___________________

Street Address: ______________________________City:______________________State:________Zip Code:_________________

Phone#'s:_______________________________________ Email Address:____

Driver's License#:___________________________ Responsible Party (Parent/Spouse) Name:_________________________
Responsible Party Phone #:__________________________ Responsible Party Date of Birth:___________________________

Insurance Information:

Employer: __________________ INS Name:_______________________ Subscribers Name:_________________________ SSN# of Subscriber/Member ID #:____________________ Date of Birth:_______________ INS Phone #'s:____________________
Address of INS:____

Health Information:
Have you ever had any of the following? Please check ALL that apply:

__ AIDS
__ ALLERGIES
__ ANEMIA
__ ARTHRITIS
__ ARTIFICIAL JOINTS
__ASTHMA
__ BLOOD DISEASE/ TRANSFUSION
__CANCER
__DIABETES
__DIZZINESS
__EPILEPSY
__EXCESSIVE BLEEDING
__FAINTING
__GLAUCOMA
__GROWTHS
__HEART DISEASE
__HEART MURMUR
__HEPATITIS
__JAUNDICE
__KIDNEY DISEASE
__LIVER DISEASE
__MENTAL DISORDER
__MVP
__NERVOUS DISORDERS
__PACEMAKER
__RADIATION TREATMENT
__RESPIRATORY PROBLEMS
__RHEUMATIC FEVER
__RHEUMATISM
__SINUS PROBLEMS
__STOMACH PROBLEMS
__STROKE
__TUBERCULOSIS
__TUMORS
__ULCERS
__VENEREAL DISEASE
__ CODEINE ALLERGY
__PENICILLIN ALLERGY
__LATEX ALLERGY
__JOINT/VALVE REPLACEMENT(S)
__HIV
__HEAD INJURIES
__HIGH BLOOD PRESSURE
__HAY FEVER
__ PREGNANT

ALLERGIC REACTIONS:________________________________ OTHER:____________________________

DO YOU TAKE ____FOSAMAX ? ___ASPIRIN THERAPY? ___BLOOD THINNERS?

Have you ever HAD any complications FOLLOWING dental treatment? __YES __NO
If YES EXPLAIN:____

Are you under the care of a physician? __YES __NO
Physicians Name:______________________________

List Current Medications:
____
____
__

Were you referred here? If YES, By Whom? ____

I ACKNOWLEGE THAT ALL INFORMATION ABOVE IS ACCURATE AND TRUE TO MY KNOWLEDGE

X____________________________________ X______________________________ DATE:___________________
(PRINT FULL NAME) (SIGNATURE)