

Mathew A. Berg, DMD

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PERSONAL INFORMATION of _____ Date _____

The personal information will help us give you the utmost consideration of your time and feelings.

It is important to have complete answers. All information is, of course, confidential.

Are you aware of having any particular dental problems? _____

Are you having any discomfort or pain? _____

How long has it been since you last visited a dental office? _____

What was done for you at that time? _____

May we ask who recommended this office? _____

Your name _____ First name, husband (or wife) _____

Home address _____ City _____ Zip _____

Home phone _____ Cell _____ Email _____

Social Sec. No. _____ Occupation _____

For what company do you work? _____ Phone _____ Ext. _____

Are you covered by any kind of dental insurance? Yes ___ No ___

If so what insurance _____

If married, occupation of your husband (or wife) _____

For what company does your husband (or wife) work? _____ Phone _____ Ext. _____

Is your husband (or wife) covered by any dental insurance? Yes ___ No ___

If so, what insurance _____

Your physician's name _____ Phone No. _____

HEALTH HISTORY

Has there been any problem in your general health within the past 5 years? (Serious illness, hospitalization, surgery) Yes ___ No ___

If so, what was the problem? _____

Have you had any form of cancer? Yes ___ No ___ If so, what type or name? _____

Date of last medical checkup _____ Attending physician _____

Date of last blood test _____ Attending physician _____

Under a physician's care now? Yes ___ No ___ If so, for what? _____

What tablets, pills or liquids do you take? (that includes aspirin, vitamins, tonics, etc.) _____

Does your physician require you to take special medication before dentistry? Yes ___ No ___ If so, what? _____

Date and year of birth _____ Husband's (or wife's) date and year of birth _____

