

**PAUL S. HERRIN, D.D.S.**  
395 DERHAKE • FLORISSANT, MO • 63031  
314-921-0070

**Patient Information:**

Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ Preferred Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_ - \_\_\_\_\_ Business # \_\_\_\_\_ - \_\_\_\_\_ Cell # \_\_\_\_\_ - \_\_\_\_\_

Date of Birth \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ SS # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Occupation \_\_\_\_\_

Email Address \_\_\_\_\_

Employer \_\_\_\_\_ Employer's Phone \_\_\_\_\_ - \_\_\_\_\_

Responsible Person \_\_\_\_\_

**Parent, Spouse Information or Responsible Party:**

Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_ - \_\_\_\_\_ Business # \_\_\_\_\_ - \_\_\_\_\_ Cell # \_\_\_\_\_ - \_\_\_\_\_

Date of Birth \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ SS # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Employer's Phone \_\_\_\_\_ - \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**Dental Insurance:**

Primary Insurance Plan \_\_\_\_\_ Phone Number \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Secondary Insurance Plan \_\_\_\_\_ Phone Number \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**I hereby authorize payment directly to the attending dentist of the group insurance benefits otherwise payable to me, but not to exceed the charges shown. I understand that I am financially responsible for any charges not covered by this authorization.**

\_\_\_\_\_  
**Signed (Insured Person)**

\_\_\_\_\_  
**Date**

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**Medical History:**

Patient Name: \_\_\_\_\_

Person to contact in case of an emergency: Name \_\_\_\_\_

Emergency Contact: Daytime Phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_ Evening Phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

Physician Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Tell us of any serious illnesses, operations, or hospitalizations in the last five years - \_\_\_\_\_

**Please CIRCLE the answers that apply to your health:**

Are you in good health? YES NO

Are you taking any blood thinners or medication to slicken your blood? YES NO If yes, drug name \_\_\_\_\_

Are you taking any medications for Osteoporosis? YES NO If yes, drug name \_\_\_\_\_

**Heart and Circulatory**

Abnormal Bleeding  
Anemia  
Angina  
Chest Pain

Fainting Spells  
Heart Attack  
Heart Murmur  
High Blood Pressure

Mitral Valve Prolapse  
Pacemaker  
Rheumatic Fever  
Stroke

**Respiratory**

Asthma or Hay Fever  
Bronchitis

Emphysema  
Shortness of Breath

Sinus Trouble  
Tuberculosis

**General**

AIDS or HIV  
Alcohol Abuse  
Arthritis  
Artificial Joints  
Cancer or Tumor  
Cold Sores  
Diabetes

Drug Abuse  
Eating Disorders  
Epilepsy or Seizure Disorder  
Hepatitis  
Immune System Problems  
Kidney Trouble  
Liver Disease

Mental Health Problems  
Painful Swollen Joints  
Persistent Cough That Produces Blood  
Persistent Swollen Glands in the Neck  
Sexually Transmitted Disease  
Stomach Ulcers  
Thyroid Problems

List any allergies: \_\_\_\_\_

**List any Medications** (include non-prescription, vitamins, birth control pills): \_\_\_\_\_

Are you pregnant? YES NO Are you nursing? YES NO

**To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.**

Signature \_\_\_\_\_

Date \_\_\_\_\_

