PATIENT INFORMATION

Today's Date_______________

Patient's Name________________________________ Nickname___________ Date of Birth_____________
Sex: M F

Street Address_________________________________ City________________ State__________
Zip_____________

Home Phone__________________________________ Cell
Phone____

Social Security Number______________________________
Email____

Check one: Single______ Married_______ Divorced_______ Separated_________ Widowed_______

If a child, Father's Name__________________________ If a child, Mother's
Name_____________________________

School Attending________________________________ Child's
Interest______________________________________

Patient Employed By_____________________________ Work
Phone____
(If patient is a minor, Father's Employer)
Present Position_________________________________

Name of Spouse_________________________________

Spouse Employed By_____________________________ Work
Phone_______________________________________
(If patient is a minor, Mother's Employer)
Present Position_________________________________

Person Responsible for Account______________________________________
Phone____________________________

Address_____________________________________ City___________________ State_________
Zip_____________

****PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED****

Dental Insurance? Yes____________ No______________

Primary Insurance Company_____________________________ Group
Number________________________________

Insurance Co.
Address____

Insured Name________________________________ Insured Social Security
Number______________________

Insured Date of Birth____________________________ Insured Employer_________________________________

Secondary Insurance Company______________________________ Group Number______________________________

Insurance Co. Address____

Insured Name_________________________________ Insured Social Security Number_______________________

Insured Date of Birth____________________________ Insured Employer_________________________________

PLEASE REVIEW INFORMATION ON THIS FORM, MAKE NECESSARY CHANGES THEN SIGN AND DATE BELOW.

Signature	Date	Signature	Date
________________________	_______________	_______________________	____________________
________________________	_______________	_______________________	____________________

MEDICAL HISTORY Date of last health care examination________________________

Reason____

Have you been hospitalized in the last 5 years? Y N If so, for what____

Do you have OR have you ever had:

	Yes	No		Yes	No
Anemia	____	____	Abnormal Heart Condition	____	____
Diabetes	____	____	Abnormal Bleeding from a cut	____	____
Epilepsy	____	____	Artificial Joint Replacement	____	____
Hepatitis	____	____	Positive Test for AIDS Virus	____	____
Rheumatic Fever	____	____	Abnormal Blood Pressure	____	____
Heart Murmur	____	____	Tuberculosis (TB)	____	____

Pregnant or chance of Pregnancy? Yes_____ No_____ If yes, how many months?__________

Are you Allergic to:

	Yes	No		Yes	No
Penicillin	_____	_____	Medication, Soap, Latex, Other?	_____	_____
Local Anesthetic	_____	_____	Please List________________________________		

Are you a smoker? Yes_____ No______ If so, How many packs per day____

Are you taking any prescription medications or herbal supplements? Yes_____ No_____ If so, Please List___________

Other Physical Conditions____

In Case of Emergency, Please Notify_______________________________________ Phone_______________________

Physician's Name____ Phone_______________________

Are you currently under a physician's care? Yes_____ No_____ If so, Please Explain___________________________

DENTAL HISTORY Date of last dental examination___________________________

May we request x-rays? Yes_____ No_____ Previous Dentist____
Have you ever had a bad dental experience? Yes_____ No_____ If so, Please Explain___________________________
Are you currently having any dental problems? ____
Have you ever had orthodontic treatment (Braces)? ____
Have you ever had periodontal therapy (Gum Treatment)? ____
Do you have full or partial dentures? Yes_____ No______ If yes, Date placed_________________________________
Do you grind your teeth? Yes_____ No_____ Do you have noise or pain in your jaw (TMJ)? Yes______ No______

I understand the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature____ Date_____________________________________

Comments____

How did you hear about our office? ____