

Patient's Information

Date: _____

Patient Name: _____

Birth Date: _____ Last _____ First _____ MI _____
 Male Female

Social Security #: _____ Married Single Child Other _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Address: _____ Street _____ Apartment # _____

City _____ State _____ Zip Code _____

**If you would like us to correspond with you by e-mail, please give us your e-mail address:

Patient's Dental & Health History

Date of Last Dental Visit: _____ Previous Dentist: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|---|---|--|---------------------------------------|
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Migraines | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Growths | <input type="checkbox"/> Nervous Disorders | |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Radiation Treatment | OTHER: |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Blood Thinner Rx | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis (type _____) | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Chemotherapy Tx | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Cortisone Medication | <input type="checkbox"/> HIV | <input type="checkbox"/> Stomach Problems | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems | |

- Have you ever had an allergic reaction to any medications? Yes No

If yes, please list: _____

- Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain: _____

- Are you now under the care of a physician? Yes No Name of Physician: _____

Phone: _____ If yes, please explain: _____

- Are you taking any medications? _____ If yes, please list: _____

- Do you use any form of tobacco? _____

- Do you have any health problems that need any further clarification? Yes No

If yes, please explain: _____

(Please turn over and complete the back. Thank you!)

Patient's Employment Information

Employer Name: _____ Occupation: _____

Insurance Information

Name of Subscriber: _____

Subscriber's Birth Date: _____ Subscriber's ID # or SSN#: _____

Subscriber's Address: _____

Subscriber's Employer Name: _____ Group #: _____

Patient's relationship to subscriber: Self Spouse Child Other _____

Insurance Company: _____ Insurance Company Phone Number: _____

*We do need copies of your dental insurance card(s). If you have more than one insurance company please let us know. Thank you.

Responsible Party Information

Name: _____ Relationship to patient: _____
 Male Female Married Single Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street _____ Apartment # _____
City _____ State _____ Zip Code _____

Whom may we thank for referring you to our practice? _____

In the event of an emergency, whom should we contact? Name: _____ Phone # _____

Thank you for choosing us to provide you with dental care. Your appointment time is reserved just for you. If you are unable to keep your appointment, please let us know at least 24 hours in advance so that we may schedule a new time for you. We reserve the right to charge for appointments cancelled or broken without 24 hours advance notice. Thank you for your consideration.

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 doctors at the next appointment without fail. I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me (or my child) during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I have read and understand all of the above information.

Signature: _____ Date: _____
(Signature of patient, parent, or guardian)

(Please read and sign the privacy notice. Thank you!)