

Referred by: _____ Today's Date: _____



PERSONAL INFORMATION

Patient Name: _____
Last First M.I.

Date of Birth: ____/____/____ SSN: ____-____-____ Male Female

Mailing Address: _____ City _____ State _____ Zip _____

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

Email Address: _____ Spouse's Name: _____

What is your preferred method of contact? Home Work Cell Email

Parent/Guardian name (if patient is a minor): _____
Mother Father

Employer (list parent/guardian's employer if patient is a minor): _____

Employer's Address: _____ City _____ State _____ Zip _____

Do you have dental insurance? Yes No If yes, please present insurance card.

Insured's Name: _____ Insured's Employer: _____

Insured's Date of Birth: ____/____/____ Insured's SSN: ____-____-____

In the event of an emergency, who should we contact? _____

Relation: _____ Home Phone: (____) _____ Work Phone: (____) _____

Who is ultimately responsible for this account? _____

MEDICAL HISTORY

Describe your general health: Excellent Good Fair Poor

Are you currently under the care of a physician? Yes No

Physician's Name: _____ Office Phone: (____) _____

Are you required to pre-medicate (with antibiotics) for dental appointments? Yes No Not Sure

Are you currently taking any medications? Yes No If yes, please list: _____

Are you allergic to any of the following?

Aspirin Codeine Erythromycin Dental Anesthetic Latex Penicillin Percodan

Other, please list: _____

Have you ever had any of the following?

- Anemia Diabetes Hepatitis Prosthetic Valves, Joints, or Implants
- Arthritis Epilepsy/Seizures High Blood Pressure Rheumatic Fever
- Asthma Glaucoma HIV/AIDS Stroke
- Blood Disorder Heart Attack/Heart Problems Kidney Problems Tuberculosis
- Cancer Heart Murmur Mitral Valve Prolapse Ulcers

Do you have any disease, condition, or problem not listed above that you think we should know about?

Do you use tobacco? Yes No If yes, how much? _____

Women: Are you pregnant? Yes No If yes, how long? _____ Are you nursing? Yes No

To the best of my knowledge, all of the above information is true and correct. If there are any changes, I will advise the doctor. I fully understand that payment in full is expected at the time services are rendered, unless other arrangements have been authorized in advance by the business manager.

Signature of Patient or Responsible Party

Date

