PATIENT_____ S.S.#_____ Birthday_____ Marital Status _____

Home Phone_____ Cell Phone_____ Work Phone_____ Ext_____

Person Responsible for Account_____ Birthday_____ SS#_____

St. Address_____ City/Zip_____ State_____ Home Phone_____

Mailing Address_____ City/Zip_____ State_____ Cell Phone_____

Employer_____ Emp Address_____ City_____ State____

Position_____ How Long_____ Work Phone_____

Responsible Persons Spouse's Name_____ S.S.#_____ Cell Phone_____

Spouse's Employer_____ Address_____ City_____ State____

Position_____ How Long _____ Work Phone_____

Former Dentist_____ City _____ State _____ Phone #_____

DO YOU HAVE DENTAL INSURANCE ☐ YES ☐ NO

PRIMARY Insurance Co._____ Plan #_____ ID#_____

Subscriber Name_____ Birthdate_____ S.S. #_____

Employer_____ Employer Phone_____ Relationship to Patient_____

SECONDARY Insurance Co._____ Plan #_____ ID#_____

Subscriber Name_____ Birthdate_____ S.S. #_____

Employer_____ Employer Phone_____ Relationship to Patient_____

EMERGENCY CONTACT_____ Phone_____ Cell Phone_____

HEALTH INFORMATION

Personal Physician_____ City_____ Phone_____

	YES	NO
1. Have you been hospitalized within the past two years?	☐	☐
2. Are you currently being treated by a physician?	☐	☐
3. Are you currently taking any medicines or drugs (including oral contraceptives)?	☐	☐
4. Are you allergic to any drugs or metals?	☐	☐
5. Have you ever had a skin rash or other reaction from metal jewelry?	☐	☐
6. Are you subject to prolonged bleeding?	☐	☐
7. Are you pregnant?	☐	☐
8. Are you dissatisfied with the appearance or color of your teeth?	☐	☐
9. Does your jaw hurt, make a clicking noise or do you snore?	☐	☐
10. Do you have difficulty in chewing your food?	☐	☐
11. Have you ever experienced any unfavorable reaction to previous dental treatment?	☐	☐
12. Do you use tobacco products?	☐	☐

CURRENT MEDICATIONS

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Have you been treated for any of the following (Please Circle):

HIV / Aids	Epilepsy	High Blood Pressure	VD or Herpes
Arthritis	Glaucoma	Kidney Problems	Stroke
Asthma	Heart Murmur	Low Blood Pressure	Jaundice
Cancer	Heart Problems	Osteoporosis	Joint Replacement
Diabetes	Hepatitis	Rheumatic Fever	Tuberculosis

MEDICATION ALLERGIES

_____
_____
_____
_____

Patient / Guardian is responsible for account balance regardless of Dental Insurance Coverage.

Signature_____ Date:_____