PATIENT INFORMATION

Name: _____

Birthdate: _____ Age_____

Gender (circle one): Male Female

Family Status: __ Married __ Single __ Divorced __ Other

Children Names and Ages_____

Address: _____ _____ (city) _____ (zip code)

Soc. Sec. #: _____ Employer: _____ Work Phone: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact: _____ Contact Phone:_____

Previous Dentist_____ Referred by_____

INSURANCE INFORMATION

Name of Insured: _____ Relationship to Patient: _____

Birthdate: _____ Soc. Sec. # _____ ID# _____

Insurance Company: _____ Group #: _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand the providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental 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.

X_____(signature of patient)

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or any medications you may be taking could have an important interrelationship with any dental treatment you may receive. So please read carefully and thank you for answering the following questions.

Are you under a physician's care?	YES	NO	(if yes, explain)_____
Have you been hospitalized or had an operation?	YES	NO	(if yes, explain)_____
Have you ever had a serious head or neck injury?	YES	NO	(if yes, explain)_____
Are you taking any medications, vitamins, or supplements?	YES	NO	(if yes, please list)_____
Do you use illegal substances?	YES	NO	_____
Do you use tobacco?	YES	NO	_____
Are you on a special diet?	YES	NO	_____

Women: Are you pregnant/trying to get pregnant?	YES	NO
Are you taking oral contraceptives?	YES	NO
Are you nursing?	YES	NO

Health History:
Please CIRCLE if you have or have ever had the following:

Heart Disease	Hypoglycemia	Chemotherapy/Radiation
Heart Murmur	Shortness of Breath/COPD	Tumors/Growths
Mitral Valve Prolapse	Tuberculosis	Chest Pains
Congenital Heart Disorder Heart	Emphysema	Cold Sores/Fever Blisters
Attack	Lung Disease	Fainting Spells/Dizziness
Pacemaker	HIV/AIDS	Frequent Headaches
Lung Disease	Pain in Jaw Joints	STD
Pneumonia	Stomach or Intestinal Ulcers	Glaucoma
Asthma	Hepatitis	Seasonal Allergies
Clot in Lungs	Nervous System Disease	High Blood Pressure
Liver Disease	Severe Headache	Low Blood Pressure
Kidney Disease	Anemia	Chronic Cough
Dialysis	Chest Pain/Angina	Chronic Fever
Thyroid Disease	Rheumatic Fever	Nasal Blockage
Cortisone/Steroid Medication	Arthritis	Convulsion
Drug Addiction	Rheumatoid Arthritis	Paralysis
Emphysema	Artificial Heart Valve	Alzheimer's
Epilepsy/Seizures	Artificial Joint	Prolonged Bleeding
Dry Mouth	Blood Disease	Collapsed Lung
Recent weight loss/gain	Bruise Easily	Psychiatric Problems
Stroke	Leukemia	
Diabetes	Cancer	
Sinus Trouble	Jaundice	

Have you ever had any serious illness not listed above? (If so, explain)_____

Are you allergic to any of the following?

__ Aspirin __ Penicillin __ Codeine __ Acrylic __Metal __ Latex __ Local Anesthetic __ Other (Explain) _____

To the best of my knowledge, the above questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the doctor and/or staff member of any changes in my (or patient's) medical status.

Signature: _____ Date: _____