(PLEASE PRINT)

PATIENT INFORMATION

Name: Mr. Mrs. Ms. Miss _____

( ) Mr. ( ) Mrs. ( ) Ms. ( ) Miss

( ) Married ( ) Single ( ) Divorced ( ) Widowed ( ) Minor ( ) Child

Date of Birth _____ Social Security # _____ Driver's License # _____

Address: _____

_____

(City) *(State)* *(Zip)*

E-mail Address: _____

Phone Numbers H: (_____)_____ W: (_____)_____ Other: (_____)_____

Employed by _____

Employer's Address: _____

RESPONSIBLE PARTY (If different from above)

Name of responsible person for your account: _____

Relationship to Patient: _____

Address: _____

_____

Phone Numbers: H:(_____)_____ W:(_____)_____ C:(_____)_____ Other:_____

Driver's License #_____

Employed by: _____

How did you hear about us? ( ) TV ( ) Yellow Book ( ) Yellow Pages

( ) Referral: Who? _____ **( ) Other:**_____

Have you taken aspirin or blood thinner in the last 3 days? ( ) Yes ( )No

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

(Women Only) Are you pregnant? ( ) Yes ( ) No ( ) Don't Know

Do you take birth control pills? ( ) Yes ( ) No

In Case of Emergency Call: _____ **Phone:** (_____)_____

Physician's Name _____ **Office Phone:** _____

PRIMARY DENTAL INSURANCE INFORMATION (if applicable):

Name of Subscriber: _____

Date of Birth: _____

Social Security #: _____

Driver's License #: _____

Employed by: _____

Employer's Address: _____

Employer's Phone#: _____

Name of Insurance Co.: _____

Policy #: _____

Group #: _____

Relationship to patient: _____

SECONDARY DENTAL INSURANCE INFORMATION (if applicable):

Name of Subscriber: _____

Date of Birth: _____

Social Security #: _____

Driver's License #: _____

Employed by: _____

Employer's Address: _____

Employer's Phone#: _____

Name of Insurance Co.: _____

Policy #: _____

Group #: _____

Relationship to patient: _____

Medical History

Do you have or have you ever had *(please check if applicable):*

- ☐ AIDS
- ☐ Allergic to Anesthetics (Novocain)
- ☐ Angina
- ☐ Asthma
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug Allergies _____
  _____
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV +
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Pace Maker
- ☐ Panic Attacks
- ☐ Parkinson's
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Heart Disease
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Steroid Therapy
- ☐ Stroke
- ☐ Tranquilizers
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Other: _____
  _____
  _____
  _____

Present Medication: _____

_____

Consent for Treatment

I understand and agree that all charts, records, radiographs (x-rays), notes, etc. without limitation are the sole property of this office to be used in any manner at the doctor's discretion in keeping with applicable privacy laws. I understand and agree that charges for radiographs (x-rays) are not for the films themselves, but rather for the professional interpretation thereof. As such I agree to pay a nominal fee for duplication of any charts, records, radiographs, notes, etc.

Signature_____ Date_____