

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
 Gender: _____ Family Status: _____
 Social Security #: _____ Birth Date: _____
 Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____
 Address: _____
Street Apartment #
City State Zip Code
 E-mail Address: _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Do you need PRE-MEDICATION for dental treatment? _____
 If so, what? _____ Why _____

Please list any medications you are using and reason _____

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

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | Due date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | OTHER: |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | |
| | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems | |

- 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 at the present time? Yes No
 If yes, please explain: _____
- Name of Physician: _____ Phone: _____
 City: _____ Date of last physical _____
- Do you have any health problems that need further clarification? Yes No
 If yes, please explain: _____

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.

Signature of patient, parent or guardian _____ Date: _____

Referral Information

How did you hear about our practice?

Another patient, friend Another patient, relative

Dental Office Yellow Pages Newspaper School Work Other _____

Name of person or office referring you to our practice: _____

Responsible Party Information

Who will be responsible for payment if different from yourself?

Name: _____

Social Security #: _____ Birth Date: _____

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

Address: _____

Street

Apartment #

City

State

Zip Code

Signature of responsible party _____

Relationship to Patient _____

Employment Information

The following is for: the patient

the person responsible for payment

Employer Name _____ Occupation: _____

Address: _____

Street

City

State

Zip Code

Phone

Insurance Information

Primary

Name of Insured: _____ is insured a patient? Yes No

Last

First

MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street

City

State

Zip Code

Insured's Employer Name: _____

Address: _____

Street

City

State

Zip Code

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

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Last

First

MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street

City

State

Zip Code

Insured's Employer Name: _____

Address: _____

Street

City

State

Zip Code

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

Insurance Plan Name and Address: _____

Signature to authorize release of information _____