Patient Information

Name First:_____ Last:_____ S.S.#_____ Birth date_____

Parent or Guardian Name (if applicable) _____

Address _____ City _____ State _____ Zip Code _____

Home Telephone _____ Work Phone _____ Cell Phone _____

Marital Status _____ Sex of Patient _____ E-mail Address_____

Referred by_____ Family Member ☐ Friend ☐ Co-worker ☐

Where have you seen us?....Website ☐ Facebook, Twitter, etc ☐ Phonebook ☐ Google, Bing, etc. ☐ Community ☐

EMPLOYMENT INFORMATION:

Employer _____

Address _____ City _____ State _____ Zip Code _____

Telephone _____ Occupation/Position _____

PRIMARY INSURANCE CARRIER:

Name of Insurance Carrier _____

Address _____

City _____ State _____ Zip Code _____

Member # _____ Group # _____

Name of Policy Holder _____

Policy Holders DOB _____ Policy Holder's SS # _____

SECONDARY INSURANCE CARRIER:

Name of Insurance Carrier _____

Address _____

City _____ State _____ Zip Code _____

Member # _____ Group # _____

Name of Policy Holder _____

Policy Holder's DOB _____ Policy Holder's SS # _____

EMERGENCY NOTIFICATION:

Name _____ Relationship _____

Address _____ City _____ State _____ Zip Code _____

Telephone _____ Work Phone _____

Name of Nearest Relative Not Living With You _____ Telephone _____

CONSENT:

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any Other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patients dental needs. I understand the use of anesthetic agents embodies a certain risk. I acknowledge and accept full financial responsibility for all services rendered and understand that I owe payment in full at the time of service unless I have made prior financial arrangement. I have read the above and I agree to abide by those policies.

Signature_____ Date_____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

Physician's Name: _____ Phone Number: _____

1. Have you ever been hospitalized, or had any major operations or serious illness? ……Yes ☐ No ☐
If so, what? _____

2. Are you under any medical treatment now? ……Yes ☐ No ☐
If yes, what is the purpose of the current care being provided? _____
_____
_____

3. Has there been a change in your health in the past year? ……Yes ☐ No ☐

4. Have you ever had a blood transfusion? ……Yes ☐ No ☐

5. Have you ever had kidney dialysis treatment? ……Yes ☐ No ☐

6. Have you ever had abnormal bleeding problems after a cut or tooth extraction? ……Yes ☐ No ☐

7. Are you now taking drugs or medications? ……Yes ☐ No ☐

If so what?_____
_____

8. Have you had any allergic reactions to ANY drugs or medicines? ……Yes ☐ No ☐
Please list:_____

9. Women: Are you pregnant? ……Yes ☐ No ☐ Estimated date of delivery _____

10. Has a physician ever informed you that you have:

Heart Ailment ……	Y ☐	N ☐	Hepatitis or Yellow Jaundice ……	Y ☐	N ☐
High Blood Pressure ……	Y ☐	N ☐	Liver Disease ……	Y ☐	N ☐
Rheumatic Fever ……	Y ☐	N ☐	Venereal Disease ……	Y ☐	N ☐
Mitral Valve Prolapse ……	Y ☐	N ☐	AIDS ……	Y ☐	N ☐
Heart Murmur ……	Y ☐	N ☐	Stomach or Intestinal Disease ……	Y ☐	N ☐
Angina ……	Y ☐	N ☐	Kidney Disease ……	Y ☐	N ☐
Stroke ……	Y ☐	N ☐	Tumors or Growths ……	Y ☐	N ☐
Blood Disease ……	Y ☐	N ☐	Diabetes ……	Y ☐	N ☐
Hemophilia ……	Y ☐	N ☐	Tuberculosis ……	Y ☐	N ☐
Asthma ……	Y ☐	N ☐	Respiratory Disease ……	Y ☐	N ☐
Epilepsy ……	Y ☐	N ☐	Joint Replacement ……	Y ☐	N ☐

Details if Yes:_____

Updates _____
_____
_____
_____