PATIENT INFORMATION

CONFIDENTIAL

Name: ______________________________ Date of Birth: __________ Phone #:______________
Address: ______________________________ City: ______________ State: ____ Zip: __________
Social Security: ______________ Employer: __________________ Work Phone #:______________
Check Appropriate Box: □ Minor □ Single □ Married □ Divorced □ Widowed ____ Male ____ Female
Person to contact in case of an emergency: ______________________ Phone #:__________________
General Dentist: ______________________
WHOM MAY WE THANK FOR REFERRING YOU:______________________________________

RESPONSIBLE PARTY □ self

Name of Responsible Party__________________DOB:__________ Relationship to Patient:__________
Address: ____SS #: ______________
Employer: __________________Phone #: __________________ Work #: ______________

INSURANCE INFORMATION

Name of Insured: __________________DOB______________Relationship to Patient: ____________
Address: ____________________________________ Home Phone: ____________________
SS#__________________ Employer: ______________________ Work Phone: ______________
Insurance Company: ______________________________ Phone #: ______________________
Member #: __________________ Group #: ____________________

MEDICAL HISTORY

Physician________________ Office Phone#: ________________ Last Exam Date: ____________

Please indicate which of the following applies to you, check only if answer is YES

□ High Blood Pressure	□ Migraine/Headaches	□ Any Transplant	□ Cancer
□ Heart Disease	□ Epilepsy/Fainting	□ Joint Replacement	□ Radiation/Chemo
□ Heart Attack/Stroke	□ Glaucoma/Visual	□ Arthritis	□ Tuberculosis
□ Heart Murmur/Defect	□ Mental/Neural	□ Herpes	□ Fatigue
□ Pacemaker	□ Tumor/Neoplasm	□ HIV	□ Swelling
□ Diabetes/Kidney Disease	□ Alcoholism/Addiction	□ AIDS	□ Ulcers
□ Thyroid/Hormonal	□ Hepatitis	□ Prosthetic Implant	□ Irregular Heart Beat
□ Hypoglycemia	□ Venereal Disease	□ Respiratory/Asthma	□ Rheumatic Fever
□ Shortness of Breath	□ Psychiatric Care	□ TMJ	□ Anemia/Bleeding

Other:____
Allergies: □ No Allergies □ Penicillin □ Latex □ Codeine □ Sulfa □Other:____________________

Are you taking any medication including non-prescription: □ YES □ NO If YES please list below
____
____

Are you under medical treatment now? □ YES □ NO If yes please explain: ______________________
Have you ever been hospitalized for any surgical operation/serious illness? □ YES □ NO
Do you use any of the following: □ Tobacco □Alcohol □Other Drugs
WOMEN ONLY: Are you pregnant or think you may be pregnant □ YES □NO
Are you nursing? □ YES □ NO
Are you taking birth control pills? □ YES □ NO

I certify that I have read and understand the above information, to the best of my knowledge, have been answered accurately. I understand that providing incorrect information can be dangerous to my health.

X______________________________ ______________________

Signature of Patient or Parent (Guardian) if minor Date