

PLEASE PRINT

Today's Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ M ___ F ___ Home Phone _____
 (last, first, middle) (Nickname)

Email _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Soc Sec # _____ Patient's Employer _____ Work Phone _____

If Patient is a College Student, Name of College _____ City _____ State _____

Other Family Members Seen _____ Whom May We Thank for Referring You _____

Person to Contact in Case of Emergency _____ Phone _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address (if different from above) _____ Home Phone _____

Driver's License # _____ Birthdate _____ Is This Person Currently a Patient in this Office _____

INSURANCE INFORMATION

Name of Subscriber _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Name of Employer _____

Address of Employer _____ City _____ State _____ Zip _____ Phone _____

Insurance Company _____ Group # _____

PATIENT MEDICAL HISTORY

The more we know about your past and present overall health, the better care we are able to give you. Please complete all the questions below. All responses are held in professional confidence.

Name of Physician _____ Phone Number _____

- List all treatment received from your physician or other medical personnel in the last 2 years EXCEPT routine examinations or visits for minor colds -- indicate whether hospitalization was required for any of these conditions:
- List any drugs or medicines which you are currently taking:
- List any drugs or medicines to which you are allergic:
- Explain any recent changes in your health:
- Circle any of the following which you have had:

Anemia	Fainting	Radiation Treatments	Rheumatic Fever	High Blood Pressure
Asthma	Hepatitis	Excessive Bleeding	Heart Trouble	Stomach Problems
Arthritis	Diabetes	Glandular Problems	Heart Murmur	Dental Apprehension
Epilepsy	Tuberculosis	Breathing Problems	Congenital Heart Problems	Hip/Knee Replacement
Stroke	Venereal Disease	Emotional Problems	Cancer	Premed
- Do you have any allergies to jewelry or metals? Yes ___ No ___ If yes, what _____
- Are you in a high risk group for AIDS? Yes ___ No ___
- Have you ever been told you have gum disease? Yes ___ No ___
- Female patients: Are you pregnant at the present time? Yes ___ No ___
- Do you use tobacco products? No ___ If yes, what kind _____
- Are you satisfied with the appearance of your mouth? Yes ___ No ___ Do you have any other specific concerns about your mouth? _____
- If you use recreational drugs, please let your doctor know before treatment begins.

Patient's Signature (If child, parent's)

Dentist's Signature