Welcome to our office!

Patient Information (CONFIDENTIAL)

Today's Date _____

Name _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
SS# _____ Check one: ___ Minor ___ Single ___ Married
Employer _____

Home Phone _____ Work Phone _____
Cell Phone _____ e-mail address _____

Spouse or Parent's Name _____ Work Phone _____
Person to contact in case of emergency _____ Phone _____
Whom may we thank for referring you? _____

Responsible Party (if different from patient) _____
Address _____ City _____ State ____ Zip _____
Home Phone _____ Work Phone _____ Relationship _____

Dental Insurance Information

Please present your **insurance card** to the receptionist.

Name of Insured _____ Relationship to patient _____
Date of Birth _____ SS# _____ Work Phone _____
Employer _____ Address of Employer _____
Insurance Company _____ Group number _____
Insurance Co. Address _____

Do you have additional **dental** insurance? _____ If yes, complete the following:
Name of Insured _____ Relationship to patient _____
Date of Birth _____ SS# _____ Work Phone _____
Employer _____ Address of Employer _____
Insurance Company _____ Group number _____
Insurance Co. Address _____

Over please

Health History

Name of Physician _____ Phone #_____ Date of last exam ____
Are you under medical treatment now? ____ If yes, for what? _____
Have you been hospitalized for illness or surgery within the last 5 years? _____
If yes, please explain _____
Are you taking any medication? ____ If yes, what are you taking? _____
Do you use tobacco products? _____ _____
_____

Are you **allergic** to any of the following? (check if yes):

____ Penicillin	____ Amoxicillin	____ Erythromycin
____ Aspirin	____ Sulfa Drugs	____ Latex rubber
____ Any metals (nickel, mercury, etc.)_____		____ Other_____

Do you have any of the following? (check if yes):

____ *Heart Disease*	____ *Rheumatic Fever*	____ *AIDS/ HIV*
____ *Heart Murmur*	____ *Mitral Valve Prolapse*	____ *Arthritis*
____ *High Blood Pressure*	____ *Joint Replacement/ Implant*	____ *Anemia*
____ *Low Blood Pressure*	____ *Liver Disease*	____ *Asthma*
____ *Heart Attack*	____ *Jaundice/ Hepatitis*	____ *Cancer*
____ *Chest Pains*	____ *Radiation Therapy*	____ *Stroke*
____ *Easily Winded*	____ *Stomach Trouble/ Ulcers*	____ *Leukemia*
____ *Angina*	____ *Epilepsy/ Convulsions*	____ *Diabetes*
____ *Pacemaker*	____ *Thyroid Problem*	____ *Tuberculosis*
____ *Kidney Disease*	____ *Respiratory Problem*	____ *Glaucoma*

Women Only (check if yes):
____ Are you pregnant or think you may be pregnant?
____ Are you nursing?
____ Are you taking oral contraceptives?

Name of previous dentist _____ Date of your last exam _____
What brings you to our office today? _____
What are your dental goals? _____
If you have missing teeth, have you considered replacing them? _____
Do you like your smile? _____

Authorization and Release

I certify that I have read and understand the above information and that I have accurately answered the above questions to the best of my knowledge. I authorize the dentist to release any information to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient, parent, or guardian ***X***_____