

Welcome

About You

Patient Name _____
If Child, Parent/Guardian _____
Patient's SS# _____ - _____ - _____
Guardian's SS# _____ - _____ - _____
Address _____
City _____ State _____ Zip _____
Age _____ Birthdate _____
Sex: M _____ F _____
Home# _____ Work# _____
Cell/Other Phone# _____
Email Address _____
Employer _____
Married _____ Single _____ Other _____
How did you find out about us?

Previous Dentist _____

In case of emergency, please notify:
_____ Ph# _____

Insurance

Primary Insurance _____
Phone# _____
Insured Name _____
Relation _____
Insured's Birth Date _____ - _____ - _____
Insured SS# _____ - _____ - _____
Insured's Employer _____
Secondary Insurance _____
Phone# _____
Relation _____
Insured's Birth Date _____ - _____ - _____
Insured SS# _____ - _____ - _____
Insured's Employer _____

We accept dental insurance assignments, with the understanding that any portion not covered by your insurance is to be paid by you. Your contract for coverage is between you and your Insurance carrier

Medical History

Physician _____ Phone# _____

Last Visit Date _____

Are you currently under the care of a Physician? Yes _____ No _____

If yes, why? _____

I consider my current health to be:

Good _____ Fair _____ Poor _____

Do you smoke or use tobacco in any form? Yes _____ No _____

Are you taking any prescription or over-the-counter drugs?

Yes _____ No _____ if yes, what? _____

What medications are you allergic to?

FOR WOMEN:

Are you pregnant? Yes _____ No _____

If yes due date? _____

are you nursing? _____

Please circle all of the medical conditions you have.

Heart Condition	Lung Disease
Venereal Disease	Heart Murmur
Artificial Heart Valve	Sinus Trouble
Heart Pacemaker	Thyroid Disease
High Blood Pressure	Kidney Problems
Rheumatic Fever	Artificial Joint
Epilepsy/Seizures	HIV Positive
Anemia/Hemophilia	Diabetes
Skin Rashes/Hives	Hepatitis
Asthma/Hay Fever	Glaucoma
Blood Transfusions	Cancer/Tumors