

Patient Information

Patient Name: _____ Date: 06/27/2010

_____ Last, First MI (Preferred Name)

Birth Date: _____ Male Female

Social Security #: _____ Married Single Child Other _____

Phone (Home): _____ (Work): _____ (Cell): _____

Would you like appointment confirmation by Phone Text Email

Email: _____

Address: _____

Street

Apt #

City

State

Zip

Emergency Contact: _____ Emergency Phone: _____

Referral Information

Whom may we thank for referring you to our practice?

Patient Website Internet Search Sign Mailer Insurance YellowPages Newspaper

Referral Name (if applicable): _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Address: _____

Street

Apartment #

City

State

Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Last

First

MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street

City

State

Zip Code

Insured's Employer Name: _____

Address: _____

Street

City

State

Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Last

First

MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street

City

State

Zip Code

Insured's Employer Name: _____

Address: _____

Street

City

State

Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Health Information

Patient Name: _____

Have you experienced any of the following?

Y N

- Angina/Chest Pain
- Breathing Problems
- Bruise Easily
- Difficulty Swallowing
- Excessive Thirst
- Fainting or Dizziness

- Frequent Cough
- Frequent Diarrhea
- Frequent Urination
- Hives or Rash
- Jaundice
- Nervousness

- Pain in Jaw Joints
- Recent Weight Loss
- Sinus Problems
- Swollen Joints

Are you allergic to:

Y N

- Penicillin
- Latex
- Aspirin
- Codeine

- Local anesthetic (Novocain/Xylocaine)
- Nitrous Oxide
- Valium
- Erythromycin
- Tetracycline

- Vicodin
- Percodan
- Food
- Metal
- Other: _____

Have you ever had any of the following? Please check those that apply:

Y N

- AIDS (HIV+)
- Allergies (Pollen Dust)
- Alzheimer's Disease
- Anemia
- Arthritis/Gout/Rheumatism
- Artificial Heart Valve
- Artificial Joints
- Asthma
- Blood Disease
- Cancer/Chemotherapy
- Cold Sores
- Congenital Heart Disorder
- Cortisone Medicine
- Diabetes
- Drug/Alcohol Addiction
- Dry Mouth
- Emphysema/Lung Disease

- Epilepsy or Seizures
- Glaucoma/Eye Disease
- Heart Attack/Failure
- Heart Murmur/Irregularity
- Hepatitis A / B / C
- Herpes
- High Blood Pressure
- Hypoglycemia
- Kidney Problems
- Leukemia
- Liver Disease
- Low Blood Pressure
- Lung Disease
- Migraines
- Mitro Valve Prolapse
- Orthodontics
- Osteoporosis

- Periodontal Treatment
- Psychiatric Care
- Radiation Treatment
- Scarlet/Rheumatic Fever
- Sickle Cell Disease
- Skin Disease
- Stroke
- Stomach Problems/ IBS
- Intestinal Problems
- Thyroid Disease
- Transplant
- Tuberculosis
- Tumors or Growths
- Ulcers
- Venereal Disease

Do you need to Pre-Medicate for your dental appointment? Yes No

Are you currently under the care of a physician? Yes No If yes, please explain _____

Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain _____

Women: (please check) pregnant / trying to get pregnant Nursing Taking oral contraceptives

Have you taken any supplements, tobacco, and alcohol or had significant weight loss in the last 3 months? _____

List all current medications: _____

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

Signature of patient, parent or guardian

Date: _____

Doctor: _____ Date: _____ Patient BP: _____