CONFIDENTIAL

Patient Information

Thank You for Choosing our Practice for your dental needs. Please Complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Name _____ Date _____
First MI Last

Social Security No. _____ Birthdate _____

Address _____ City, State Zip _____

Home Phone # _____ Work Phone # _____ Extention _____

Cell Phone # _____

Are you: Minor _____ Married _____ Divorced _____ Widowed _____

Single _____ Separated _____

Are you: Male _____ Female _____

You or Your Parent's employer _____ Occupation _____

Spouse's or Parent's Name _____ Work Place _____

Work # _____

If you are a student, name of School/college _____

City, State _____

Person to contact in case of Emergency _____

Phone # _____

Responsible Party

Name of Person responsible for account? _____ Relationship to Patient _____

Phone # _____ Address _____

Name of Employer _____ Work # _____

Dental Insurance Information

Primary Carrier

Name of Insured _____ Relationship to Patient _____

Policy Holder Birthdate _____ Social Security # _____

Name of Employer _____ Work # _____

Insurance Company _____ Group # _____

Policy ID # _____ Insurance Co. Phone # _____

DO YOU HAVE ADDITIONAL INSURANCE? Yes _____ NO _____

Name of Insured _____

Relationship to Patient _____ Birthdate _____

Social Security # _____

Name of Employer _____ Work # _____

Insurance Company _____ Group # _____

Policy ID # _____

I understand that responsibility for payment for Dental Services provided for myself or my dependents is mine, due and payable at the time services are rendered unless prior arrangements have been made.

Signature _____ Date _____

Patient Medical History

Please answer all questions & sign and date below:

PERSONAL HISTORY

1. Are you now under the care of a Physician? Yes / No

If so what are you being treated for? _____

Physician Name _____ Phone # _____

Physician Address _____

2. Are you taking any drug, medicine, or pills? (Prescription or over the counter) If so, what?

_____

_____

3. Are you being treated for Osteoporosis? Yes / No

4. Have you ever been told to be premedicated with an antibiotic before dental work? Yes / No

5. Have you had abnormal bleeding associated with previous extraction, surgery or trauma? Yes / No

6. Are you currently taking any Blood Thinners? Yes / No

Prescription Name: _____

7. Do you have or have you had any of the following diseases or Problems? **(INDIVIDUALY CIRCLE EACH ONE YES OR NO)**

	Description	*Date / Type		Description
Yes / No	Artificial Heart Valve	*	Yes / No	Heart Murmur
Yes / No	Artificial Joint	*	Yes / No	Leaky Heart Valve
Yes / No	Heart Attack	*	Yes / No	Mitral Valve Prolapse
Yes / No	Heart Surgery	*	Yes / No	Epilepsy or Seizures
Yes / No	Pacemaker	*	Yes / No	High Blood Pressure
Yes / No	Other Heart Conditions		Yes / No	Low Blood Pressure
Yes / No	Diabetes (Type)	*	Yes / No	Stroke
Yes / No	Hepatitis		Yes / No	Tuberculosis (Active or Passive)
Yes / No	Radiation	*		Date TX Completed?
	Date of Last Treatment?		Yes / No	Hip or Joint Replacement
Yes / No	Pregnant		Yes / No	Kidney Disease
	Trimester?		Yes / No	Asthma
Yes / No	Chemotherapy	*	Yes / No	Back Problems
Yes / No	Organ Transplant		Yes / No	Chemical Dependency
	Organ Type ?		Yes / No	Fainting
Yes / No	Tobacco Habit		Yes / No	Jaw Pain
Yes / No	Positive to HIV (Aids)		Yes / No	Thyroid Disorder

8. Are you allergic or have you ever reacted adversely to:

Yes / No	Local Anesthetics	Yes / No	Iodine	Yes / No	Aspirin	Yes / No	Latex
Yes / No	Penicillin	Yes / No	Sulfa Drugs	Yes / No	Codeine		
Yes / No	Barbiturates	Yes / No	Erythromycin	Yes / No	Other Antibiotics		

Emergency Contact:

Name _____ Relationship _____

Phone # _____

To the best of my knowledge the above medical and dental history is correct. I hereby consent to such examinations and diagnostic procedures deemed necessary for dental treatment. I also authorize the doctor to perform any and all forms of treatment, medication and therapy.

Patient /Guardian Signature _____ *Date* _____