

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name) Gender: _____ Family Status: _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ Cell number: _____
E-Mail Address _____
Address: _____
Street Apartment #
City State Zip Code

Patient Employment Information

Employer Name: _____ Occupation: _____
Address: _____
Street City, State Zip Code Phone

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Do you have or have you ever had any of the following? Please check those that apply

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Asthma | <input type="checkbox"/> Herpes | <input type="checkbox"/> Thyroid - hyper |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid - hypo |
| <input type="checkbox"/> Allergy - Codeine | <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Allergy - Penicillin | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Allergy - Morphine | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Liver Disease | |
| <input type="checkbox"/> Allergy - Epinephrine | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mental Disorders | OTHER: |
| <input type="checkbox"/> Allergy - Latex | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Allergy - Iodine | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Allergy - Metal _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Allergy - Sulpha | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Allergy - _____ | <input type="checkbox"/> Growths | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Allergy - _____ | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Rheumatism | Female Patients: |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sinus Problems | Are you pregnant? _____ |
| | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Stomach Problems | Due date: _____ |

- List current medications: _____
- Do you have to pre-medicate with an anti-biotic prior to your dental appointments? Yes No
If yes, please explain: (ie: Mitral Valve Prolapse, Heart Murmur...) _____
- Have you ever had any complications following dental treatment? 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: _____
- Are you now under the care of a physician? Yes No Condition: _____
Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

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

Date: _____

Spouse or Responsible Party Information

The following is for: the Patient the Patient's spouse Other _____

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #
City State Zip Code

Insurance Information

Primary Insurance

Name of Policy Holder: _____ Is Policy Holder a patient? Yes No

Policy Holder's Birth Date: _____ ID #: _____ Group #: _____
Last First MI

Policy Holder's Address: _____
Street City State Zip Code

Policy Holder's Employer Name: _____
Address: _____
Street City State Zip Code

Patient's relationship to Policy Holder: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Phone Number to Member Services/Customer Services : _____

Secondary Insurance

Name of Policy Holder: _____ Is insured a patient? Yes No

Policy Holder's Birth Date: _____ ID #: _____ Group #: _____
Last First MI

Policy Holder's Address: _____
Street City State Zip Code

Policy Holder's Employer Name: _____
Address: _____
Street City State Zip Code

Patient's relationship to Policy Holder: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Phone Number to Member Services/Customer Services : _____

Emergency Contact Person

Name: _____ Phone (H): _____ (W): _____

Relationship to Patient _____ (Cell): _____

Referral Information

Who may we thank for referring you or how did you hear about our practice?
