

Patient Information (Please Print)

Name _____ Social Sec. # _____ Date of Birth _____
 First MI Last

Address _____ City _____ State _____ Zip _____

Home Phone _____ **Cell Phone** _____ **E-mail** _____

Employer _____ Occupation _____ **Work Phone** _____

Business Address _____ City _____ State _____ Zip _____

Marital Status _____ Spouse's Name _____ Employer & Work Phone _____

How did you hear about our office? _____

Reason for today's visit? _____

Responsible Party (if other than patient)

Person responsible for this account _____ Relationship to Patient _____

Home Phone _____ Date of Birth _____ Social Sec. # _____

Address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____ Work Phone _____

Dental Insurance Information **Please provide a copy of the insurance benefit card and/or military identification**

Policy Holder/Subscriber _____ Relationship to Patient _____

Home Phone _____ Date of Birth _____ Social Security # _____

Employer _____ Group # _____ Policy/ID # _____

Insurance Co. Address & Phone # _____

Do you have any additional dental insurance? If yes, please complete the following:

Policy Holder/Subscriber _____ Relationship to Patient _____

Home Phone _____ Date of Birth _____ Social Security # _____

Employer _____ Group # _____ Policy/ID # _____

Insurance Co. Address & Phone # _____

Signature of Patient/Parent/Guardian/Guarantor **Date**

Signature of Patient/Parent/Guardian/Guarantor **Date**

If for a dependent 18 year of age or older, on patient or guardian account we will need signature of the responsible party for this accounts and also the patient signature. If 18 years of age or older on account other than your own or spouse(legal guardian or power of attorney) we will need the signature of the party taking responsibility for your account. If not we will have to place you on your own account.

**See Financial and Insurance Agreement/ Authorization and Release
OVER**

Patient's Name _____

Reason for Today's Visit _____ Date of last dental visit _____

Emergency Contact _____ Phone # _____

Emergency Contact (not living with you) _____ Phone # _____

MEDICAL HISTORY

Physician's Name & Phone # _____ Date of last examination _____

Are you currently taking any medications? **YES NO**

List _____

Any Allergies? **YES NO** (Jewelry/Metal, Latex, Skin, Environmental, Medications)

List _____

Do you have a history of the following? Please answer either YES (Y) or NO (N) to each.

- | | | | |
|-----------------------------|---------------------------|----------------------------|-------------------------|
| Y N AIDS/HIV Positive | Y N Diabetes*- Type _____ | Y N Kidney Disease | Y N Rheumatic Fever |
| Y N Anemia | (Controlled Y N) | Y N Low Blood Pressure | Y N Scarlet Fever |
| Y N Arthritis | Y N Eating Disorder | Y N Lung Disease | Y N Seizures |
| Y N Artificial Heart Valves | Y N Fainting | Y N Malignant Hyperthermia | Y N Shortness of Breath |
| Y N Asthma | Y N Glaucoma- Type _____ | Y N Migraines | Y N Sinus Trouble |
| Y N Back/Neck Problems | Y N Hay fever | Y N Mitral Valve Prolapse | Y N Stomach Problems |
| Y N Blood Clots | Y N Heart Murmur | Y N Nervous Problems | Y N Stroke |
| Y N Blood Disease | Y N Heart Problems | Y N Pacemaker | Y N Swollen Ankles |
| Y N Blood Transfusion | Y N Hemophilia | Y N Prolonged Bleeding | Y N Thyroid Problems |
| Y N Cancer | Y N Hepatitis- Type _____ | Y N Psychiatric Care | Y N Tobacco Habit |
| Y N Canker Sores | Y N Herpes | Y N Radiation Treatment | Y N Tonsillitis |
| Y N Chemical Dependency | Y N High Blood Pressure | Y N Recent Weight Loss | Y N Tuberculosis |
| Y N Chemotherapy | Y N Jaw/TMJ Pain | Y N Respiratory Problems | Y N Venereal Disease |
| Y N Circulatory Problem | Y N Joint Replacements | | * or family history |

If there is any health information you need to discuss privately with us, feel free to let us know.

(WOMEN) Any chance you are pregnant? **YES NO** Planning on becoming pregnant in the next year? **YES NO**
Are you nursing? **YES NO** Taking birth control pills? **YES NO**

Are you taking herbal medicines or supplements? **YES NO**

Have you ever had EYE SURGERY? **YES NO**
Type of surgery _____ Date of Surgery _____

Do you plan on having EYE SURGERY in the next year? **YES NO**

Is there anything else we should know about your health? **YES NO**
EXPLAIN _____

Patient's Signature _____ Date _____

Parent/Guardian Signature _____ Date _____
(if patient is under the age of 18)