PATIENT INFORMATION

GENERAL

DATE: _____

Name: _____ Sex: M F Birthdate: _____ Soc. Sec.# _____

O Minor O Single O Married O Divorced O Widowed O Separated O Partnered

Address: _____ City/State _____ Zip _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mailAddress: _____

Patient or Parent Employer: _____ O Full Time O Part Time

Name of Spouse/Parents/Partner: _____ School _____

Who referred you to our office? _____

RESPONSIBLE PARTY

Who will pay for this account? _____ Relationship to Patient _____

Address: _____ Phone: _____

Employer: _____ Is this person a patient in our office? Yes No

Please provide your Driver's License to be copied.

DENTAL INSURANCE INFORMATION

PRIMARY Insured Name _____ Relationship

Birthdate _____ Soc. Sec. # _____ to patient _____

Employer _____ Insurance Co _____ Work Phone _____

ID# _____ Group # _____ Cust Serv Phone _____

SECONDARY Insured's Name _____ Relationship

Birthdate _____ Soc Sec # _____ to patient _____

Employer _____ Insurance Co _____ Work Phone _____

ID# _____ Group# _____ Cust Serv Phone _____

MEDICAL/DENTAL HISTORY

Physician's name: _____ Phone: _____ Date of last exam _____

Yes	No		Yes	No	
___	___	Are you under medical treatment now?	___	___	Are you taking any medications? If yes please list
___	___	Have you ever been hospitalized?			_____
___	___	Have you had serious illness or any surgical operations? List _____			_____
					_____
___	___	Do you use alcohol?	**WOMEN ONLY:**		
___	___	Do you use tobacco?	___	___	Are you Pregnant or think you might be pregnant?
___	___	Are you taking Tranquilizers or Sedatives	___	___	Are you Breast Feeding?
___	___	Are you taking Cortisone Drugs, Steroids, or Blood Thinners. (please circle)	___	___	Are taking birth control pills?

Do you have or have you had any of the following? Please Check

___AIDS/HIV	___Dizziness/Fainting	___Herpes	___Rheumatic Fever
___Anemia	___Emphysema	___High Blood Pressure	___Respiratory Problems
___Angina	___Epilepsy/Seizures	___Joint Replacement	___Sexually transmitted disease
___Arthritis	___Glaucoma	___Kidney Disease	___Sinus Problems
___Asthma	___Handicaps/Disabilities	___Leukemia	___Stomach troubles/ulcers
___Blood Disorder	___Heart Defects	___Liver Disease	___Stroke
___Cancer/ Tumors	___Heart Murmur	___Low Blood Pressure	___Thyroid Disease
___Cardiac Pacemaker	___Hemophilia	___Migraines	___Tonsilitis
___Diabetes	___Hepatitis A or B or C	___Radiation Therapy	___Tuberculosis
	___Hay Fever		___Yellow Jaundice

Are you allergic to any of the following medications?

___Aspirin	___Dental Anesthesia	___Jewelry	___Metals	___Tetracycline
___Codeine	___ Erythromycin	___Latex	___Penicillin	___Other: _____