Please take a few minutes to answer the following questions so we can better assist you with your dental care needs.

PATIENT INFORMATION

Today's Date _____ Birthdate _____ Patient Social Security # _____

Patient Name _____
(LAST NAME) (FIRST NAME) (INITIAL)

Address _____

City _____ State _____ Zip _____

Occupation _____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Other

Patient Home Phone _____ Patient Cell Phone _____

Email Address _____

Employer _____ Employer Phone _____

Employer Address _____

In Case of Emergency Contact

Name _____ Relationship _____

Emergency Home Phone _____ Emergency Cell Phone _____

Whom may we thank for referring you to us? _____

PRIMARY DENTAL INSURANCE

Individual responsible for this account _____
(LAST NAME) (FIRST NAME) (INITIAL)

Relationship to patient _____ Birthdate _____ Social Security # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Insurance Company _____

Subscriber ID # _____ Group # _____

ADDITIONAL DENTAL INSURANCE

Insured Individuals Name _____
(LAST NAME) (FIRST NAME) (INITIAL)

Relationship to patient _____ Birthdate _____ Social Security # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Insurance Company _____

Subscriber ID # _____ Group # _____

Women	Y	N	DURING THE PAST 12 MONTHS, HAVE YOU TAKEN ANY OF THE FOLLOWING?		
Are you taking contraceptives or other hormones?	☐	☐	☐ Antibiotics or sulfa drugs	☐ Tranquilizers	☐ Digitalis
Are you pregnant?	☐	☐	☐ Anticoagulants	☐ Insulin, Orinase	☐ Nitroglycerin
Are you nursing?	☐	☐	☐ High Blood Pressure Meds	☐ Aspirin	☐ Cortisone
			☐ Chemotherapy	☐ Other_____	

MEDICATIONS	ALLERGIES	
List medications or supplements you are currently taking _____ _____ _____ _____ _____ _____ **Do you pre-medicate? ☐ Y ☐ N** _____ Pharmacy _____ Phone _____	☐ Aspirin ☐ Barbiturates ☐ Codeine ☐ Iodine ☐ Latex ☐ Local Anesthetic ☐ Penicillin ☐ Sulfa ☐ Reaction to Metals	☐ Other (please list) _____ _____ _____ _____ _____ _____ _____ _____ _____

Some health conditions are hereditary. Information that you can furnish us pertaining to your immediate family members; brothers, sisters, parents and grandparents will give us a better understanding of your total health needs.

RELATIONSHIP TO YOU	PRESENT AND PAST HEALTH PROBLEMS YOUR FAMILY MEMBER HAS HAD

CHECK ANY SYMPTOMS OR CONDITONS BELOW YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR

☐ AIDS	☐ Dizziness/Fainting	☐ Irregular Heartbeat	☐ Persistent Cough
☐ Arm Pain or Numbness	☐ Double Vision	☐ Itching	☐ Pneumonia
☐ Arthritis	☐ Excessive Thirst	☐ Jaundice	☐ Poor Circulation
☐ Artificial Heart Valve	☐ Emphysema	☐ Kidney Disease	☐ Prostate Problem
☐ Artificial Joints	☐ Epilepsy	☐ Leg Pain/Numbness	☐ Rapid Heartbeat
☐ Asthma	☐ Fever	☐ Liver Disease	☐ Rash
☐ Back Pain or Numbness	☐ Forgetfulness	☐ Loss of Hearing	☐ Rheumatic Fever
☐ Bleeding Disorders	☐ Glaucoma	☐ Loss of Sleep	☐ Sinus Problems
☐ Bleeding Gums	☐ Hand Pain/Numbness	☐ Loss of Weight	☐ Sore That Won't Heal
☐ Blood Disease	☐ Headache	☐ Low Blood Pressure	☐ Stomach Aches/Pains
☐ Bruise Easily	☐ Head Injury	☐ Migraine Headaches	☐ Stroke
☐ Cancer	☐ Heart Disease	☐ Mitral valve Prolapse	☐ Sweats
☐ Chemical Dependency	☐ Heart Murmur	☐ Multiple Sclerosis	☐ Swelling Ankles
☐ Circulatory Problems	☐ Hepatitis	☐ Mumps	☐ Thyroid Problem
☐ Chest Pain	☐ Herpes	☐ Nausea	☐ Tuberculosis
☐ Chicken Pox	☐ High Blood Pressure	☐ Neck Pain/Numbness	☐ Ulcers
☐ Chills	☐ High Cholesterol	☐ Neuralgia	☐ Varicose Veins
☐ Diabetes	☐ Hip Pain or Numbness	☐ Neuritis	☐ Vision Flashes
☐ Diarrhea	☐ HIV Positive	☐ Nose Bleeds	☐ Vomiting
☐ Depression/Nervousness	☐ Hives	☐ Pacemaker	
☐ Difficulty Swallowing	☐ Indigestion	☐ Parkinson's	

☐ Other: _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____