

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Antibiotics or sulfa drugs	<input type="checkbox"/> Tranquilizers	<input type="checkbox"/> Digitalis
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Anticoagulants	<input type="checkbox"/> Insulin, Orinase	<input type="checkbox"/> Nitroglycerin
Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure Meds	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Cortisone
			<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Other _____	

MEDICATIONS	ALLERGIES	
List medications or supplements you are currently taking _____ _____ _____ _____ _____	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Other (please list) _____
	<input type="checkbox"/> Barbiturates	_____
	<input type="checkbox"/> Codeine	_____
	<input type="checkbox"/> Iodine	_____
	<input type="checkbox"/> Latex	_____
	<input type="checkbox"/> Local Anesthetic	_____
	<input type="checkbox"/> Penicillin	_____
	<input type="checkbox"/> Sulfa	_____
	<input type="checkbox"/> Reaction to Metals	_____
Do you pre-medicate? <input type="checkbox"/> Y <input type="checkbox"/> N _____		
Pharmacy _____		
Phone _____		

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

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