



PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Patient Name _____
Last First MI (Preferred)
 Birthdate _____ SS# _____ DL# _____ Gender: M F Married: Y N
 Work Phone _____ Cell Phone _____ Email _____

If patient is under 18 yrs, please also complete the following:

Guarantor Name _____
Last First MI (Preferred)
 Birthdate _____ SS# _____ DL# _____ Gender: M F Married: Y N
 Work Phone _____ Cell Phone _____ Email _____
 Student status if dependent over 19 (for ins) Nonstudent Fulltime Part time
 How did you hear about us? (Please be specific so we can thank them!) _____

ADDRESS AND HOME PHONE

Check circle if same for entire family:
 Address _____
 Address 2 _____
 City _____ State _____ Zip _____
 Home Phone _____

INSURANCE POLICY 1

Patient relationship to subscriber: Self Spouse Child
 Subscriber Name _____ Sub.ID # _____ Sub.DOB _____
 Insurance Company _____ Phone _____
 Employer _____ Group Name _____ Group # _____

INSURANCE POLICY 2

Patient relationship to subscriber: Self Spouse Child
 Subscriber Name _____ Sub.ID # _____ Sub.DOB _____
 Insurance Company _____ Phone _____
 Employer _____ Group Name _____ Group # _____

Comments: _____

Please complete reverse side.

FINANCIAL AGREEMENT

- * For my convenience, this office may release my information to my insurance, and receive payment directly from them.
- * If sent to collections, I agree to pay a **\$30 collection fee**, all related fees and court costs.
- * Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
- * Treatment plans may change, and I will be responsible for the work actually done.

Signature _____ Date _____

MEDICAL HISTORY

Name of Medical Doctor: _____ City/State _____

Emergency Contact _____ Phone _____ Relationship _____

List all the medications or drugs you are now taking:

Check medications or drugs you are allergic to:

[] None

- ! None
- ! Aspirin
- ! Codeine/ Other Narcotics
- ! Erythromycin
- ! Latex Rubber
- ! Local Anesthetics
- ! Metals
- ! Penicillin
- ! Sulfa Drugs
- ! Other: _____

Check any medical conditions you may have:

- ! None
- ! AIDS/HIV
- ! Alcohol/Drug Abuse
- ! Anemia/Leukemia
- ! Anorexia/Bulimia
- ! Arthritis
- ! Asthma/Hay Fever
- ! Blood Clotting Problems
- ! Blood Transfusion
- ! Bronchitis
- ! Cancer/Tumor or Growth
- ! Cardiac Pacemaker
- ! Chest Pain Upon Exertion
- ! Damage Heart Valve
- ! Other: _____
- ! Diabetes
- ! Emphysema
- ! Epilepsy
- ! Fainting Spells/Seizures
- ! Fever Blisters/Herpes
- ! Frequent Headaches
- ! Frequently Dry Mouth/Sjogren
- ! Gall Bladder Trouble
- ! Heart Attack/Stroke
- ! Heart Disease/Angina
- ! Heart Murmur
- ! Hepatitis/Jaundice
- ! High Blood Pressure
- ! Hives/Skin Rash
- ! Joint Replacement, Date of: _____
- ! Kidney/Bladder Trouble
- ! Liver Disease
- ! Low Blood Pressure
- ! Mental Health Problems
- ! Mitral Valve Prolapse
- ! Persistent Diarrhea
- ! Rheumatic Fever
- ! Rheumatic Heart Disease
- ! Sexually Transmitted Disease
- ! Sinus Trouble
- ! Stomach Ulcers
- ! Thyroid Problems
- ! Tuberculosis

WOMEN ONLY- Are you pregnant or do you have reason to believe you may be? ! Yes / ! No

Tobacco use? If so, what kind and how much? _____

Unusual reaction to dental injections? _____

Reason for today's visit: _____ Are you in pain? Yes / No

New patients:

Name of former dentist _____ City/State _____

Date of last cleaning and exam _____

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Name (printed)

Date

Patient/Guardian Signature