Welcome, and thank you for selecting our dental healthcare team!

We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us . . . we will be happy to help.

Patient #:

Soc. Sec. #:

Patient Information (Confidential)

Date:

Name	Date of Birth:	Home Phone:
Address	City/State	Zip Code:
Check Appropriate Box: Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐		
Patient's or Parent's Employer:		Work Phone:
Business Address:	City/State:	Zip Code:
Spouse or Parent's Name:	Employer:	Work Phone:
If Patient is a Student, Name of School/College:		City/State:
Whom may we thank for referring you?		
Person to contact in case of emergency:		Phone:
Email Address:		

Responsible Party

Name of person responsible for this account:		Relationship to Patient:
Address:		Home Phone:
Driver's License:	Date of Birth:	Financial Institution:
Employer:		Work Phone:
Is this person currently a Patient in our office? Yes ☐ No ☐		

Insurance Information

Name of Insured:		Relationship to Patient:
Date of Birth:	Soc. Sec. #:	Date Employed:
Name of Employer:		Work Phone:
Address of Employer:	City/State:	Zip Code:
Insurance Company:	Group #:	Union or Local #:
Ins. Co. Address:	City/State:	Zip Code:
How much is your deductible:	How much have you used:	Max. Annual Benefit:
Do you have any additional insurance? Yes ☐ No ☐ If yes, complete the following:		
Name of Insured:		Relationship to Patient:
Date of Birth:	Soc. Sec. #:	Date Employed:
Name of Employer:		Work Phone:
Address of Employer:	City/State:	Zip Code:
Insurance Company:	Group #:	Union or Local #:
Ins. Co. Address:	City/State:	Zip Code:
How much is your deductible:	How much have you used:	Max. Annual Benefit:

Medical History. Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have any important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Patient #:

Soc. Sec. #:

Are you under a physician's care now? Yes ☐ No ☐	If yes, please explain:
Have you ever been hospitalized, or had a major operation? Yes ☐ No ☐	If yes, please explain:
Have you ever had a serious head or neck injury? Yes ☐ No ☐	If yes, please explain:
Are you taking any medications, pills or drugs? Yes ☐ No ☐	If yes, please explain:
Do you take, or have you taken, Phen-Fen or Redux? Yes ☐ No ☐	If yes, please explain:
Are you on a special diet? Yes ☐ No ☐	If yes, please explain:
Do you use tobacco? Yes ☐ No ☐	Women: Are you pregnant or trying to get pregnant? ☐
Do you use controlled substances? Yes ☐ No ☐	Nursing? ☐ Taking oral contra captives? ☐

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other: If yes, please explain:

Do you have, or have you had, any of the following:

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores / Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disease	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack / Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis / Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble / Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells / Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? Yes ☐ No ☐ If yes, please explain:

Additional Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian: Date: