



Patient Information and Health History

First Name: _____ Last Name: _____ MI _____

Sex: Male Female

Birth Date: _____ Age: _____

Marital Status: Married Single Divorced Other

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell: _____

Birth Date: _____

Payment Methods: Check/Cash Credit /Debit Card

(Insurance copayments are due on the day of service)

Patient Is: (Check all that apply) Responsible Party Policy Holder Dependant/Child

If Minor: Responsible Party _____

Employer _____

Employment Status: Full Time Part Time Retired None

Student Status: Full Time Part Time

Emergency Contact: _____ Phone# _____

Pharmacy: _____ Previous Dentist: _____

Whom may we thank for referring you? _____

Insurance

Please present your insurance card to reception desk

Payment of deductibles and copays are expected the day of service. Treatment estimates are available upon request.

Insurance Information

Policy Holders Name: _____

Policy Holders Date of Birth: _____

Insurance Company Name/Address: _____

Employer: _____ Employer Phone #: _____

Insurance ID#: _____ Group#: _____ Policy #: _____

Relationship to insured Self Spouse Child Other

Health Questions

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

Physician _____ Office Phone _____

Have you ever been hospitalized or had a major operation? Yes No

Medications List

Have you had a serious head or neck injury? Yes NO

If answered yes to any of the above please explain:

Women: Are you:

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following? (Circle)

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other

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

AIDs/HIV	yes	No	Prednisolone Medicine	Yes	No	Hemophilia	Yes	No	Anemia	Yes	No
Immunodeficiency problem	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Asthma	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Frequent Diarrhea	Yes	No	Easily Winded	Yes	No	Recent Weight Loss	Yes	No	Blood Transfusion	Yes	No
Bruise Easily	Yes	No	Emphysema	Yes	No	Herpes	Yes	No	Shingles	Yes	No
Artificial Joint Replacement	Yes	No	Epilepsy or Seizures	Yes	No	Renal Dialysis	Yes	No	Sickle Cell Disease	Yes	No
Osteoporosis	Yes	No	Fainting Spells/Dizziness	Yes	No	Sinus Trouble	Yes	No	Cold Sores/Fever Blisters	Yes	No
Heart Murmur	Yes	No	Heart Attack/Failure	Yes	No	Kidney Problems	Yes	No	Use tobacco	Yes	No
Mitral Valve Prolapse	Yes	No	Congenital Heart Disorder	Yes	No	Leukemia	Yes	No	Hormone Replacement	Yes	No
Heart Pace Maker	Yes	No	Stroke	Yes	No	Liver Disease	Yes	No	Tuberculosis	Yes	No
Blood Pressure Low/High	Yes	No	Frequent Headaches	Yes	No	Hypoglycemia	Yes	No	Thyroid Disease	Yes	No
Excessive Bleeding	Yes	No	Irregular Heartbeat	Yes	No	Lung Disease	Yes	No	Pain in Jaw Joints/Surgery	Yes	No
Cancer	Yes	No	Angina	Yes	No	Tumors or Growths	Yes	No	Bell's Palsy	Yes	No
Chemotherapy or Radiation	Yes	No	Artificial Heart Valve	Yes	No	Herbal Supplements	Yes	No		Yes	No

Explain:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X

Signature of patient (Or parent/guardian of Minor)

Date