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: ________________**Cell:**_______________**Email**__________________________

Contact Preference: ☐ **Home** ☐ **Cell Phone** ☐ **Text: Provide Cell Carrier**_______________ ☐ **Email**

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: ____

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Employer: __________________________ Employer Phone #: ______________________

Insurance ID#: _________________________Group#: _____________

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

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

Medications List

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If answered yes to any of the above please explain:

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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? (Check or 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:

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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 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

Print out form and bring to appointment; or click button to send form to us.