Date_____ **PATIENT INFORMATION**

Name_____ **SS#**_____
(last name) (first name) (MI)

Address_____
(street) (city) (zip code)

Home Phone_____ **Cell Phone**_____ **Work phone**_____

Sex M__ **F**__ **Birthdate**_____ **Age**____ **Married**__ **Single**__ **Divorced**__ **Widowed**__ **Separated**__

Patient's Employed by_____ **Occupation**_____

Person Responsible for Account (if other than self)_____
(last name) (first name) (MI)

Relation to Patient_____ **Birthdate**_____ **Soc. Sec. #**_____

Address (if different from patient) _____
(street) (city) (zip code)

Person Responsible Employed by _____

Business Address _____ **Business Phone** _____
(street) (city) (zip code)

Notify in case of emergency_____ **Relationship to Patient**_____

Home Phone_____ **Work Phone**_____ **Cell Phone**_____

Whom may we thank for referring you?_____

PRIMARY DENTAL INSURANCE

Subscriber Name _____ **Relation to Patient** _____
(last name) **(first name)** **(MI)**

Birthdate _____ **Soc. Sec. #** _____

Insurance Company_____ **Phone**_____

Subscriber or ID #_____ **Group #**_____

ADDITIONAL DENTAL INSURANCE

Is patient covered by additional insurance? Yes____ **No**____

Subscriber Name_____ **Relation to Patient**_____ **Birthdate**_____

Address (if different than patient) _____ **Soc. Sec.#**_____
(street) (city) (zip code)

Subscriber Employed by_____ **Business Phone**_____

Insurance Company_____ **Phone**_____

Subscriber or ID #_____ **Group #**_____

HEALTH HISTORY

Medical Doctor's Name_____ **Phone**_____

Date of last visit_____ **Have you had any serious illnesses or operations? Yes No**

If yes, describe_____

Are you currently under physician care? Yes No If yes, describe_____

Have you ever had a blood transfusion? Yes No If yes, give approx. dates_____

Women: Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check (X) if you have had any of the following:

___Mitral Valve Prolapse	**___High Blood Pressure**	**___Cancer**	**___Anaphylaxis**
___Heart Murmur	**___Hemophilia/Abnormal Bleeding**	**___Chemotherapy**	**___Tobacco Habit**
___Artificial Heart Valves		**___Radiation Treatment**	**___Chemical Dependency**
___Rheumatic/Scarlet Fever	**___Herpes**	**___Back Problems**	**___Psychiatric Care**
___Artificial Joints	**___AIDS/HIV Positive**	**___Jaw Pain**	**___Fainting**
___Hepatitis	**___Veneral Disease**	**___Skin Rash**	**___Nervous Problems**
___Diabetes	**___Stroke**	**___Cortisone Treatments**	**___Asthma**
___Tuberculosis	**___Respiratory Disease**	**___Kidney Disease**	**___Arthritis/Rheumatism**
___Circulatory Problems	**___Cough Up Blood**	**___Liver Disease**	**___Epilepsy**
___Pacemaker/Heart Surgery	**___Shortness of Breath**	**___Ulcer/Colitis**	**___Rapid Weight Gain**
___Anemia	**___Thyroid Disease**	**___Glaucoma**	**___Rapid Weight Loss**

Have you had surgery or x-ray treatment for a tumor, growth or other condition on your head or neck? Yes No

Do you have any diseases, conditions, or problems not listed you think we should know about? Yes No
If so, please explain_____

MEDICATIONS

List any medications or herbals you are currently taking and the correlating diagnosis:

_____
_____
_____
_____
_____

ALLERGIES

___Aspirin **___Local Anesthetic**
___Penicillin **___Codeine**
___Sulfa **___Iodine**
___Latex **___Barbiturates (**sleeping pills**)**
___Other_____
_____
_____

APPOINTMENT CONFIRMATION PREFERENCES

Appointments will be confirmed approximately 48 hours prior to your appointment. In the future we will be confirming appointments according to your personal preferences. Please list your first, second and third contact preference.

Personal Phone Call ____ **Preferred Phone Number _____**
Text Message _____ **Preferred Cell Phone Number _____**
email Message _____ **email Address _____**

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of a third party to confirm appointments.

Signature_____ **Date**_____