Patient Information
(This Information is necessary for our files and will be considered confidential)

Today's Date___________________ Email address: __________________________

Patient's Name_________________________ Age_______ Date of Birth___________

Home Address_______________________________ Home Telephone (____) ________

City and State__________________________ Zip Code________________ Cell Phone (____) ___________

SOCIAL SECURITY#_______________________ Driver's License No._____________

Patient is: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse's Name ___________________________ Social Security # _____________________

Employed by _________________ Occupation ____________ Business Phone: (___) _______

Name of nearest relative not living with you__________________ Phone No. (___)________
Relationship to you____________________

Name of Physician_____________________ Telephone No. (____)_____________

Former Dentist__________________________ Who referred you?___________________

FINANCIAL INFORMATION

Person responsible for account:________________________ Relationship_______________

If Different than above give address______________________ Phone No. (___)________

All Payments must be made on the day of treatment, including estimated insurance deductibles and co-payments. You are responsible for payment on your account, regardless of your insur. company's payment or nonpayment. Insur. company's give estimates only; they do not guarantee payment.

We Offer Care Credit if you need to make payments on amounts over $300. Care Credit offers free payments for three, six, or twelve months, depending on the amount and subject to credit approval.

SIGNED:___________________________ DATE:_________________

PLEASE FILL OUT IF YOU HAVE INSURANCE

Name of insurance company: ___________________________ Group #:_________________

Address:_________________________ Phone# (____)___________

Primary Insured's Name_______________ Soc. Security #____________ D.O.B.__________

Do you have dual insurance? ____ If so, Secondary Insur. Co.:______________________

Group #___________ Address: _________________________ Phone # (___) ___________

Secondary Insurd's Name: ____________________ SS#______________ D.O.B._________

TURN OVER AND FILL OUT HEALTH HISTORY!

HEALTH QUESTIONAIRE

(These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with oral health care.)

1. Are you in good health? ☐ Yes ☐ No
2. Date of your last physical exam: ________________
3. Are you now under the care of a physician? ☐ Yes ☐ No
4. Have you ever had any serious illness or operation? ☐ Yes ☐ No
   If so, for what illness or operation? ____________________________________
5. Are you taking medication? ☐ Yes ☐ No If so, what for? ___________________________

Please List your medications: ____

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6. Have you ever been pre-medicated with antibiotics for your dental treatment? ☐ Yes ☐ No
7. Are you sensitive or allergic to any drugs? ☐ Penicillin ☐ Tetracycline ☐ Sulfa Drugs
☐ Aspirin ☐ Codeine ☐ Other Drugs: (stipulate)__________________________

8. Allergies? If so, to what? ________________________ Latex Allergy? ☐ Yes ☐ No
9. Have you ever taken Fen-phen or Redux? ☐ Yes ☐ No

Do you have or ever had any of the following?:

	Yes	No		Yes	No
Scarlet Fever	☐	☐	Rheumatic Fever	☐	☐
Hepatitis or Jaundice	☐	☐	Aids or related complex	☐	☐
Artificial limbs or joints	☐	☐	Excessive Bleeding	☐	☐
Heart Murmur	☐	☐	Hemophilia	☐	☐
Bruise Easily	☐	☐	Heart Lesions	☐	☐
Swallowing problems	☐	☐	Cold Sores	☐	☐
High blood pressure	☐	☐	Heart Failure	☐	☐
Anemia	☐	☐	Stroke	☐	☐
Heart Aliments/Attack	☐	☐	TMJ (Temporomandibular)	☐	☐
Diabetes	☐	☐	Pain in jaw joints	☐	☐
Sinus Trouble	☐	☐	Ulcers	☐	☐
Emphysema	☐	☐	Thyroid Disease	☐	☐
Kidney Disease	☐	☐	Drug or alcohol addiction	☐	☐
Seizures	☐	☐	Blood Transfusion	☐	☐
Cancer	☐	☐	Fainting spells/seizures	☐	☐

Please List any others not listed: ____

10. Do you wear a cardiac pacemaker or have you had heart surgery? ☐ Yes ☐ No
11. Do you have any disease, condition or problem not listed that I should know about? ☐ Yes ☐ No
    If so, what? ____________________________
12. Do you Smoke? ☐ Yes ☐ No If yes, how much per day? __________________________
13. (Women) Are you pregnant? ☐ Yes ☐ No If so, how many months? _____________

DENTAL HISTORY

Have you ever had a local anesthetic? (Novacaine, etc.) ☐ Yes ☐ No

Have you ever had any serious trouble associated with any previous treatment? ☐ Yes ☐ No

Date of last dental treatment? ___________ How long since your last full mouth x-ray? __________

OFFICE USE ONLY-MEDICAL HEALTH UPDATE

1.____ DATE: _________________

2.____ DATE: _________________

3.____ DATE: _________________