Thank you for choosing our practice! We look forward to taking care of all your dental needs.

PATIENT INFORMATION (PLEASE PRINT)

First Name_____ Middle Initial_____ Last Name_____

Date of Birth_____ Gender M ☐ F ☐ Social Security #_____

Address_____ Apt_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

E-mail_____@_____.com or .net Driver's License #_____

Marital Stat us ☐Single ☐Married ☐Widowed ☐Other ☐Employment Status ☐Full Time ☐Part Time ☐Retired ☐Student FT/ PT

Emergency Contact Name _____ Emergency Phone_____

DENTAL INSURANCE INFORMATION

Insurance Name _____ Group / Policy / ID #_____

Subscriber_____ Relationship_____ Date of Birth_____

Subscriber SS#_____ Phone_____

Employer's Name_____ Occupation_____

MEDICAL HISTORY

Primary Care Physician_____ Phone_____

Do you have or have ever had any of the following? Please check ONLY those that apply:

☐ Heart Murmur ☐ Epilepsy ☐ Special Diet

☐ High Blood Pressure ☐ Headaches ☐ Swollen Neck Glands

☐ Low Blood Pressure ☐ Hepatitis, Jaundice or Liver Disease ☐ Rheumatic Fever

☐ Circulatory Problems ☐ Cancer ☐ Sinus Problems

☐ Nervous Problems ☐ Psychiatric Care ☐ AIDS / HIV

☐ Radiation Treatment ☐ Mitral Valve Prolapse ☐ Thyroid Disease

☐ Artificial Heart Valves or Joints ☐ Allergies to Anesthetics ☐ Stroke

☐ Recent Weight Loss ☐ Allergies to Medicine or Drugs ☐ Ulcer

☐ Back Problems ☐ General Allergies ☐ Venereal Disease

☐ Diabetes ☐ Blood Disease ☐ Chemical Dependency

☐ Respiratory Disease ☐ Arthritis ☐ Hemophilia

Do you have any DRUG ALLERGIES or have you ever had an adverse reaction to any medication?_____ if so, to what_____

Are you taking any medication at this time? _____ if so, which_____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No If yes, please explain_____

Women only: Are you pregnant? ☐ Yes ☐ No Due Date?_____ Are you nursing? ☐ Yes ☐ No

Whom may we thank for referring you?

_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.