PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name_____
Last First MI (Preferred)

Birthdate_____ SS#_____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Work Phone_____ Wireless Phone_____ Wireless Carrier_____

Email_____

Preferred contact method [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Preferred contact method for confirmations [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Preferred contact method for recall [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Student status if dependent over 19 (for ins) [ ] Nonstudent [ ] Fulltime [ ] Parttime

How did you hear about us?

_____

(If someone referred you here, please write down their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family [ ]

Address_____

Address 2_____

City_____ State_____Zip_____

Home Phone_____

INSURANCE POLICY 1

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____Subscriber ID # _____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____Subscriber ID # _____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

Comments:

Medical History

Last Name: First Name: Birthdate:

Name of Medical Dr: City/State:

Emergency Contact: Phone: Relationship:

List all medications that you are now taking: Pharmacy:

Are you allergic to any of the following? No to All :_____

Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Acrylic
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Ibuprofen	☐	☐	Sulfa

Do you have any of the following medical conditions? NO to All:_____

Y	N		Y	N	
☐	☐	Acid Reflux	☐	☐	Herpes
☐	☐	AIDS/HIV	☐	☐	High Blood Pressure
☐	☐	Alzheimers Disease	☐	☐	High Cholesterol
☐	☐	Anaphylaxis	☐	☐	Hives/ Rash
☐	☐	Anemia	☐	☐	AutoImmune Disease
☐	☐	Angina	☐	☐	Kidney Problems
☐	☐	Arthritis/ Gout	☐	☐	Liver Disease
☐	☐	Artificial Heart Valve	☐	☐	Low Blood Pressure
☐	☐	Artificial Joint	☐	☐	Lung Disease
☐	☐	Asthma	☐	☐	Mitral Valve Prolapse
☐	☐	Bleeding Problems	☐	☐	Osteopenia/ Osteoporosis
☐	☐	Cancer	☐	☐	Pain in Jaw Joints
☐	☐	Chemical Dependency	☐	☐	Psychiatric Care
☐	☐	Chemotherapy	☐	☐	Radiation Treatments
☐	☐	Chest Pain	☐	☐	Renal Dialysis
☐	☐	Congenital Heart Disorder	☐	☐	Rheumatic Fever
☐	☐	Cold Sores/ Fever Blisters	☐	☐	Shingles
☐	☐	Convulsions/ Seizures	☐	☐	Sinus Trouble
☐	☐	Depression/ Anxiety	☐	☐	Smoking
☐	☐	Diabetes	☐	☐	Stomach/ Intestinal Disease
☐	☐	Glaucoma	☐	☐	Stroke
☐	☐	Hay Fever	☐	☐	Thyroid Disease
☐	☐	Heart trouble/ disease	☐	☐	Tonsillitis
☐	☐	Heart Murmur/ Irregular Heart Beat	☐	☐	Tuberculosis
☐	☐	Heart Pacemaker	☐	☐	Tumors or Growths
☐	☐	Hemophilia	☐	☐	Ulcers
☐	☐	Hepatitis A / B / C	☐	☐	Venereal Disease

WOMEN: Pregnant/ Trying to get pregnant?

Are you taking or taken Fosamax, Boniva, Actonel or any Bisphosphonates?

Do you need to Pre Medicate before dental treatment?

Unusual reaction to dental injections?

Reason for today's visit ?

Are you in pain?

New patients:

Name of referring dentist? City/State

Date of last cleaning and exam?

Date: Signature: