To help us meet your dental needs, please fill out this form completely. If you have any questions, please ask someone at the front desk and we will be happy to help you. Thanks for being our patient!

Patient Information

Name_____ _____ _____
Last First MI Preferred Name Title

□ Male □ Female □ Single □ Married □ Other

Date of Birth_____ SSN_____ Driver's Lic. #_____ State_____

Address_____
City State Zip

Phone (H)_____ (W)_____(Cell) _____

E-mail_____

Emergency Contact Name_____ Emergency Contact Phone_____

How did you hear about us?_____

Referred by patient (name) _____Referred by doctor (name) _____

Dental Insurance Information

Primary Plan Member Information:

Insurance Co. Name _____ Insurance Co. Phone # _____ Group# _____

Name of Insured_____ Insured's Date of Birth _____ Insured SS# _____
Month/Day/Year

Member ID#_____ Insurance Address _____

Insured's Relationship to Patient_____ Insured's Employer _____

Do you have dual coverage? Yes_____ No_____ If yes:

Assignment and Release
I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company and assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature on all insurance submissions.

X_____ _____ _____
Responsible Party Signature Relationship to patient Date

Dental History

Reason for today's visit _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

□ Y □ N Sensitivity to hot or cold □ Y □ N Bleeding gums □ Y □ N Clicking or popping jaw

□ Y □ N Sensitivity to sweetness □ Y □ N Sensitivity when biting □ Y □ N Broken/cracked fillings

□ Y □ N Tobacco use □ Y □ N Gums swollen or tender □ Y □ N Bad breath

□ Y □ N Grinding teeth □ Y □ N Orthodontic treatment □ Y □ N Periodontal treatment

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Health History Information

Physician's Name _____ Phone number _____ Date of last visit _____

Have you ever take any of the group of drugs collectively referred as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). □ Yes or □ NO

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Heart (Surgery, Disease, Attack)...	Yes	No	Ulcers	Yes	No	Hepatitis A B C (circle) ...	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S./H.I.V. Positive	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	Cold Sores/Fever Blisters	Yes	No
High/Low Blood Pressure	Yes	No	Contact lenses	Yes	No	Blood Transfusion	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Hemophilia	Yes	No
Artificial Heart Valve/Pacemaker	Yes	No	Chronic Cough	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Tuberculosis	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Asthma	Yes	No	Liver Disease/Yellow Jaundice ..	Yes	No
Cortisone Medicine	Yes	No	Hay Fever/Allergy/Hives	Yes	No	Neurological Disorders	Yes	No
Swollen Ankles	Yes	No	Latex Sensitivity	Yes	No	Epilepsy or Seizures	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Fainting or Dizzy Spells	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Nervous/Anxious	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Psychiatric/Psychological Care..	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Cancer	Yes	No

Women:

Are you pregnant? □ yes □ no Due Date_____ Are you nursing? □ Yes □No

Taking birth control pills? □ Yes □No

Medications

Please list any medications that you are now taking. Include non-prescription medications, vitamins or supplements:

Medication	Dosage	For what purpose?	Medication	Dosage	For what purpose?

Allergies

□ Aspirin □ Barbirurates (sleeping pills) □ Codeine □ Iodine □Latex □ Local Anesthetic

□ Penicillin □ Sulfa □ Other _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

_____ _____

Patient Signature Date