Today's date_____

Patient
Name_____DOB_____SSN_____
Last First MI

Residence_____
Number and street City State Zip

Phone_____Employer_____Phone_____
Home Work

Cell phone_____Which number shall we use to confirm appointments? H C

Marital status_____Spouse's name_____SSN_____

Parent or
spouse's employer_____Phone_____
Work

Nearest relative not living with you:
Name and address_____Phone_____

Person responsible for financial arrangements_____
Method of payment_____Cash_____Check_____Visa/MC/Disc_____Insurance
Name of dental insurance carrier_____
Name of insured (or insureds if dual coverage)_____
SS# of insured employee_____DOB_____

I understand this office will file insurance claims on my behalf as a courtesy to me. I understand that I, in conjunction with any insurance benefits, am responsible for payment of dental services provided to me. I understand that if a change to my scheduled appointment becomes necessary, a 24 hour notice is required to avoid a cancellation fee.

Signature_____

Whom may we thank for referring you to our office?_____

Have you had any serious trouble associated with previous dental treatment?_____
Do you wear a denture, partial denture, bridge or hearing aid? Yes No Which?_____
Are you happy with your smile? Yes No
Do you clench or grind your teeth? Yes No
Do your gums bleed when brushed? Yes No
Do you use dental floss? Yes No How often?_____
Do you have frequent headaches? Yes No
Do your jaw joints pop or make noise? Yes No
Do you use tobacco products? Yes No Which?_____
Have you been told you have periodontal disease? Yes No

continued on back

Do you have, or have you had, any of the following? If YES, please check.

__Abnormal blood pressure
__Allergies
__Anemia
__Artificial joint by Dr._____Date_____
__Asthma or emphysema
__Blood disorders
__Cancer
__Diabetes
__Drug addiction, alcohol abuse
__Epilepsy or convulsions
__Frequent cold sores
__Heart attack
__Heart valve replacement
__Hepatitis
__Mitral valve prolapse
__Other heart ailment
specify:_____
__Pacemaker
__Prolonged bleeding
__Recent weight loss
__Rheumatic fever
__Seizures, dizziness, fainting
__Stroke
__Treatment for osteoporosis
__TB, AIDS, HIV
__Ulcers
__Use a C-PAP
__X-ray therapy

Are you allergic to, or have you reacted adversely to any of the following:

__Any Anesthetic
__Penicillin
__Aspirin
__Other_____
__Other antibiotic
__Codeine
__Any metal
__Latex

List ALL medications you are taking now, including aspirin, alternative medicines, herbs and OTC meds_____

_____

_____

Name of Physician_____Last physical exam_____
Are you also being treated by a specialist? Yes No Name _____
For what?_____

Have you had any serious illness or surgery in the past 2 years? Yes No
If so, what and when_____

If female, are you pregnant? Yes No Due date_____

Do you have any disease, condition or problem not listed above that we should know about?
Please explain_____

Signature of patient_____Date_____

rev 3/14 **********

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