PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Miss	Last Name of Patient	First	Middle	Preferred Name	Home #	Cell #	Birth Date

Home Address _____ City _____ State _____ Zip _____

Email Address _____

Person responsible for account

Name _____

Address _____

SS# Patient _____

SS# Spouse _____

Referred by _____

Your employer _____

Address/City/Zip _____

Telephone at Work _____

Spouse's employer _____

Address/City/Zip _____

Telephone at Work _____

Name, Address & Phone Number
of nearest relative not living with you _____

MEDICAL HISTORY

1. Are you in good health? _____ Have you ever been hospitalized? _____
2. Are you under physician's care? _____ If yes, give reason _____
   _____ Physician's name _____ Telephone _____
3. What medications are you taking at this time? _____
4. Have you ever had to take any medication before seeing a dentist? _____
5. Please circle any illness you have ever had:

Allergies	Asthma	Tuberculosis	Anemia	Rheumatic Fever		
Liver Trouble	Heart Trouble	High Blood Pressure	Kidney Trouble	Jaundice	Hepatitis	VD
Epilepsy	Stroke	Stomach Ulcers	Head Injuries	Rheumatism or Arthritis		Sinus Trouble
Radiation Treatment	Tumors or Growth	Mitral Valve Prolapse	Heart Murmur	Other _____		

6. Are you subject to any nervous disorders, dizzy spells or fainting? _____
7. Have you ever had any trouble with prolonged bleeding? _____
8. Have you ever had an unusual or allergic reaction to any anesthetic or drug (like penicillin or codeine)? _____
9. Do you now, or have you ever abused drugs (including alcohol)? _____
10. Have you ever been tested for the AIDS virus? _____ If yes, have you tested positive? _____
11. Are you pregnant? _____ How many months? _____
12. Is there any other information that should be known about your health? _____
13. Any joint replacements or implants? _____

INSURANCE

Primary Carrier
Employee
Insurance Co. _____
Employer _____
Birth Date _____
Group # _____ SS # _____

Secondary Carrier
Employee
Insurance Co. _____
Employer _____
Date Employed _____
Group # _____ SS # _____

I authorize payment of insurance benefits directly to the dentist of record (signature) _____

I authorize release of any necessary medical info. to Ins. Company (signature) _____

CONSENT

The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agent embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself of my dependents is mine.

Patient _____ Date _____

Parent or Responsible Party _____ Relation to Patient _____