PATIENT INFORMATION AND HISTORY
(Confidential information for our records)

(Please print clearly) SOC.SEC#__________________________

NAME____AGE_____BIRTHDATE________________________
(Last name) (First) (M.I.)

PREFERRED FIRST NAME__________________________EMAIL ADDRESS____

HOME ADDRESS____CITY_____________________ZIP_______________

HOME PHONE_____________________WORK PHONE______________________CELL PHONE_______________________

EMPLOYED BY____OCCUPATION___________________________________

SPOUSE'S NAME______________________________
REFERRED BY________________________________RELATIONSHIP TO YOU______________________________________

EMERGENCY CONTACT #1____
EMERGENCY CONTACT #2____

DENTAL INSURANCE INFORMATION

NAME OF PRIMARY DENTAL INSURANCE______________________________________GROUP#______________________
NAME OF PRIMARY INSURED__________________________________RELATIONSHIP TO PATIENT___________________
ADDRESS (if different than above)_______________________________PHONE # (if different)__________________________
PRIMARY INSURED SOC. SEC#__________________________BIRTHDATE______________________________________
EMPLOYED BY____
EMPLOYER'S ADDRESS____ZIP_____________________
EMPLOYER'S PHONE#__________________________________

NAME OF SECONDARY DENTAL INSURANCE__________________________________GROUP#______________________
NAME OF SECONDARY INSURED______________________________RELATIONSHIP TO PATIENT___________________
ADDRESS (if different than above)_______________________________PHONE # (if different)__________________________
SECONDARY INSURED SOC. SEC#______________________BIRTHDATE______________________________________
EMPLOYED BY____

DENTAL/MEDICAL HISTORY

When was your last visit to a dentist?______________________
Name of dentist you were treated by?______________________
Have you had a full mouth X-ray?__________________________
Have you been told by a doctor that you have to take an anti-biotic before dental cleanings/procedures ______________________
Do you have any of the following conditions? **(please circle)**
High Blood Pressure – Heart Trouble – Diabetes – Asthma
Anemia – Tuberculosis – Kidney or Liver involvement
Blood Disease – AIDS – Arthritis – Ear Trouble
Rheumatic Fever – Epilepsy – Hepatitis
(Please indicate yes or no)
Are you sensitive or allergic to any medications or anesthetics?
____
Are you subject to profuse bleeding?______________________
(Women)Are you pregnant?____________________________
Are you under the care of a Physician?______________________
If Yes, for what purpose?__________________________________

Are you taking any medication now?______________________
If yes, please list them and tell us why you are taking them.
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____
____
____
____
Have you had any major surgery within the last 5 years?_________
If yes, please explain_____________________________________
____
Have you ever had radiation treatment to the neck/head ?________
Who is your Medical Physician?___________________________
Phone#____
REMARKS____
____
____
____

Please give us at least 48 hours notice if unable to keep your appointment. Failure to notify this office of cancellations, within this time period will result in a $25.00 charge. Failure to show up for your appointment will result in a $35.00 Charge.

I understand that I am financially responsible for the charges incurred. In the event that I fail to pay these charges, I will be responsible for the collection fee associated with the cost of resolving my account.

Signature X____ Date__________________________