Welcome, and thank you for selecting ou We will strive to provide you with the best possible dental care. T	Patient #:						
needs, please fill out this form completely in ink. If you have any us we will be happy to help.	Soc. Sec. #:						
Patient Information (Confidential)	Date:						
Name	Date of Birth:	Home Phone:					
Address	City/State	Zip Code:					
Check Appropriate Box: Minor ☐ Single ☐ Marrie	ed Divorced Widowed	Separated					
Patient's or Parent's Employer:	Work Phone:						
Business Address:	City/State:	Zip Code:					
Spouse or Parent's Name:	Employer:	Work Phone:					
If Patient is a Student, Name of School/College:	City/State:						
Whom may we thank for referring you?							
Person to contact in case of emergency:	Phone:						
Email Address:	Email Address:						
Responsible Party							
Name of person responsible for this account:	Relationship to Patient:						
Address:	Home Phone:						
Driver's License:	Date of Birth:	Financial Institution:					
Employer:	Work Phone:						
Is this person currently a Patient in our office? Yes No							
Insurance Information							
Name of Insured:	Relationship to Patient:						
Date of Birth:	Soc. Sec. #:	Date Employed:					
Name of Employer:	Work Phone:						
Address of Employer:	City/State:	Zip Code:					
Insurance Company:	Group #:	Union or Local #:					
Ins. Co. Address:	City/State:	Zip Code:					
How much is your deductible:	How much have you used:	Max. Annual Benefit:					
Do you have any additional insurance? Yes ☐ No ☐	If yes, complete the following:						
Name of Insured:	Relationship to Patient:						
Date of Birth:	Soc. Sec. #:	Date Employed:					
Name of Employer:	Work Phone:						
Address of Employer:	City/State:	Zip Code:					
Insurance Company:	Group #:	Union or Local #:					
Ins. Co. Address:	City/State: Zip Code:						
How much is your deductible:	How much have you used:	Max. Annual Benefit:					

Medical History. Although dental personnel primarily treat the area in and				Patient #:		
your mouth is part of your entire body. Health problems that you may have, or medic taking, could have any important interrelationship with the dentistry you will receive. answering the following questions.			Soc. Sec. #:			
Are you under a physician's care now? Yes \(\square\) No \(\square\)			If yes, please explain:			
Have you ever been hospitalized, or had a major operation? Yes ☐ No ☐			If yes, please explain:			
Have you ever had a serious head or neck injury? Yes ☐ No ☐			If yes, please explain:			
Are you taking any medications, pills or drugs? Yes ☐ No ☐			If yes, please explain:			
Do you take, or have you taken, Phen-Fen or Redux? Yes ☐ No ☐		If yes, please explain:				
Are you on a special diet? Yes No No		If yes, please explain:				
Do you use tobacco? Yes ☐ No ☐			Women: Are you pregnant or trying to get pregnant?			
Do you use controlled substances? Yes ☐ No ☐		Nursing? ☐ Taking oral contra captives? ☐				
Are you allergic to any of t	he following?					
☐ Aspirin ☐ Penic	cillin 🗌 Codeine 🗎 Ad	crylic	☐ Latex ☐ Loc	cal Anesthet	ics	
☐ Other: If yes, please e	explain:					
Do you have, or have you had, any of the following:						
☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headache	es Irregular He	artbeat	☐ Scarlet Fever	
☐ Alzheimer's Disease	☐ Cold Sores / Fever Blisters	☐ Genital Herpes	☐ Kidney Prob	olems	☐ Shingles	
☐ Anaphylaxis	☐ Congenital Heart Disease	☐ Glaucoma	☐ Leukemia		☐ Sickle Cell Disease	
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Diseas	se	☐ Sinus Trouble	
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack / Failu	re	Pressure	☐ Spina Bifida	
☐ Arthritis / Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Diseas	se	☐ Stomach/Intestinal Disease	
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve	Prolapse	☐ Stroke	
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble / Disc	ease	Joints	☐ Swelling of Limbs	
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid	Disease	☐ Thyroid Disease	
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric	Care	☐ Tonsillitis	
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Ti	reatments	☐ Tuberculosis	
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Wei	ght Loss	☐ Tumors or Growths	
☐ Bruise Easily	☐ Fainting Spells / Dizziness	☐ High Blood Pressur	re Renal Dialys	sis	□ Ulcers	
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic I	Fever	☐ Venereal Disease	
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatisn	n	☐ Yellow Jaundice	
Have you ever had any serious illness not listed above? Yes ☐ No ☐ If yes, please explain:						
Additional Comments:						
To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be						
dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.						
Signature of Patient, Parent, or Guardian: Date:						