Patient Information

Patient Name: _____ Preferred Name: _____
Last First MI

[ ] Male [ ] Female [ ] Married [ ] Single [ ] Child [ ] Other

Social Security #: _____-_____-_____ Birth Date:___/___/___Age:_____ Drivers License #: _____

Phone (Home): _____ (Work): _____ Ext._____ (Fax): _____

(Mobile): _____ (Pager): _____ (Other): _____

Address: _____
Street Apartment #

_____
City State Zip Code

Patient Employment Information

Employer Name: _____

Address: _____
Street Suite #

_____
City State Zip Code

Spouse Information

Name: _____ Preferred Name: _____
Last First MI

Social Security #: _____-_____-_____ Birth Date:___/___/___Age:_____ Driver License #: _____

Phone (Home): _____ (Work): _____Ext._____ (Fax):_____

Employer: _____ Address: _____

Referral Information

Whom may we thank for referring you to our practice? [ ] Patient: _____

[ ] Dental Office [ ] Yellow Pages [ ] Newspaper [ ] School [ ] Work [ ] Other: _____

Emergency Contact

Name: _____ Preferred Name: _____
Last First MI

Phone (Home): _____ (Work): _____ Ext._____ (Fax): _____

(Mobile): _____ (Pager): _____ (Other): _____

Have you ever had or do you have any of the following? Please mark those that apply.

CARDIOVASCULAR
[ ] Mitral Valve Prolapse
[ ] Heart Trouble
[ ] Heart Murmurs
[ ] Rheumatic Fever
[ ] High Blood Pressure
[ ] Low Blood Pressure
[ ] Stroke

RESPIRATORY
[ ] Respiratory Disease
[ ] Asthma
[ ] Hay Fever
[ ] Allergies
[ ] Tuberculosis

GENITOURINARY
[ ] Kidney Disease
[ ] Bladder Infections

BONES AND JOINTS
[ ] Back or Neck Injuries
[ ] Artificial Joints

SPECIAL ORGANS
[ ] Eye/Ear/Nose/Throat
[ ] Sinusitis
[ ] Headache
[ ] Facial Injuries
[ ] Tooth Aches
[ ] Bleeding Gums
[ ] Fever
[ ] Pneumonia
[ ] High Fever Disease
[ ] Pregnancy
[ ] Menstrual Problems

ENDOCRINE
[ ] Goiter Problem
[ ] Thyroid Problem
[ ] Diabetes
[ ] Family with Diabetes

OTHER
[ ] _____

GASTROINTESTINAL
[ ] Stomach Problems
[ ] Intestinal Problems
[ ] Jaundice
[ ] Hepatitis
[ ] Liver Trouble
[ ] Gall Bladder

NERVOUS
[ ] Nervous Disorders
[ ] Mental Disorders
[ ] Depression
[ ] Epilepsy
[ ] Convulsions

BLOOD
[ ] Blood Disease
[ ] Dizziness
[ ] Fainting Spells

OTHER
[ ] Tumors
[ ] Growths
[ ] Cysts
[ ] Major Operations
[ ] Hospitalizations

IMMUNODEFICIENCY
[ ] HIV Positive
[ ] AIDS

LIST MAJOR OPERATIONS

Please circle any of the following medications that you are allergic to or have had adverse reactions to:

Aspirin
Darvon
Codeine
Demerol
Vicodin
Percodan
Nitrous Oxide
Valium
Librium
Nembutal/Seconal
Tetracycline
Erythromycin
Keflex
Penicillin
Novacaine/Xylocain
Cipro/Flagyl/Lincocin
Zithromax

Are you aware of being allergic to any other medication or substance?
Please List: _____

Do you smoke/snuff/chew? _____ How much per week? _____

Do you drink alcohol? _____ How much per week? _____

Are you pregnant? _____ What month? _____

Please list any medications that you are taking _____

_____

RELEASE, CONSENT, AND RECEIPT OF PRIVACY NOTICE:
I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I authorize release of any information to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that responsibility for payment for dental services provided in this office is mine, regardless of insurance coverage or contracts and is due and payable at the time services are rendered. I understand that my dental care insurance carrier or payment of my dental benefits may pay less than actual bill for services.

Signature _____ ***Date*** _____

Dental Insurance Company _____ Phone Number _____

Insurance Co. Address _____ Group Number _____

_____

Insured's Name _____ I.D. Number _____