Patient Information

Patient Name: Last _____ First _____ MI _____

DOB:_____ Sex: M / F Email Address:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Mailing Address:

Street:_____ City:_____ State:_____ Zip:_____

Whom may we thank for referring you? _____

Emergency Contact: _____ Phone Number:_____

Insurance Information

Primary Insurance:_____ Subscriber:_____

Subscriber ID# _____ DOB:_____ Employer: _____

Medical/Dental History

Physician's Name: _____ Date of Last Physical _____

Have you had (or currently have) any of the following? (Check all that apply)

General Allergies	Allergies to Medications/Drugs	Allergies to Local Anesthetics
Heart Problems	Artificial Heart Valves	Joint Replacement
Asthma	Eye Problems/Glaucoma	Epilepsy
High Blood Pressure	Low Blood Pressure	Blood Disorder (Anemia etc…)
Tuberculosis	Emphysema	Hepatitis, Liver Disease
Headaches	Psychiatric Care	Fainting Spells, Convulsions
Ulcer	Digestive Problems/G.E.R.D.	HIV/AIDS
Rheumatic Fever	Kidney Disease	Stroke
Cancer	Radiation	History of Drug Abuse
Venereal Disease	Back Problems	Prolonged Bleeding
Diabetes	Hemophilia	

Do you have any drug allergies or have you had an adverse reaction to any medications? If yes please explain:

_____

Are you taking any medications at this time? If yes please list_____

_____

_____

Have you ever responded adversely to medical or dental treatment? If yes please explain:

_____

Are you currently under the care of a physician? Yes / No _____

Have you had any major surgeries, joint/heart valve replacements etc…? Yes / No _____

Have you had a serious accident involving your head or jaw? Yes / No _____

Is there anything in your medical history that has not been asked? Yes / No _____

Women: Are you pregnant? Think you may be pregnant Are you nursing

Assignment and Release

I hereby authorize my insurance benefits to be paid directly to the dentist and for the dentist to release any information required to process my dental claims. I authorize the dentist to use my records as she determines necessary for my dental care, including sending x-rays to a referring doctor. I certify that I have read or had read to me the contents of this form.

Signature _____ Date _____