

Patient Information

Patient Name: _____ Date: _____

Gender: M F Marital Status: Married Single Birth Date: _____ Social Security #: _____

Driver's License #: _____ E-Mail Address: _____

Address: _____

Street

Apartment #

City

State

Zip Code

Phone #'s: Home _____ Work _____ Ext _____ Best time to call: _____

FAX _____ Pager _____ Other _____

Referral Information

Name of person, office or other source referring you to our office: _____

Spouse or Responsible Party Information

Name: _____ Spouse Parent Other _____ Date: _____

Last

First

MI

(Relationship to Patient)

Gender: M F Marital Status: Married Single Birth Date: _____ Social Security #: _____

Driver's License #: _____ E-Mail Address: _____

Address: _____

Street

Apartment #

City

State

Zip Code

Phone #'s: Home _____ Work _____ Ext _____ Best time to call: _____

FAX _____ Pager _____ Other _____

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____

Address: _____

Street

City

State

Zip Code

Phone

Insurance Information

Primary:

Name of Insured: _____

Last

First

MI

Insured's Birthdate: _____ SS #: _____ Group #: _____

Insured's Address: _____

Street

City

State

Zip Code

Insured's Employer Name: _____

Address: _____

Street

City

State

Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Company/Plan Name and Address: _____

Secondary:

Name of Insured: _____

Last

First

MI

Insured's Birthdate: _____ SS #: _____ Group #: _____

Insured's Address: _____

Street

City

State

Zip Code

Insured's Employer Name: _____

Address: _____

Street

City

State

Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Company/Plan Name and Address: _____

Medical Information

Does your medical history include any of the following:

Artificial Heart Valves*	Y	N	Liver Disease	Y	N
Artificial Joints/Hip*	Y	N	Mental Disorders	Y	N
Asthma	Y	N	Mitral Valve Prolapse*	Y	N
Bacterial Endocarditis*	Y	N	Nervous Disorders	Y	N
Cancer	Y	N	Pacemaker	Y	N
Chemotherapy	Y	N	Pulmonary Shunts*	Y	N
Congestive Heart Failure	Y	N	Radiation Treatment	Y	N
Coumadin/Blood Thinner Therapy	Y	N	Rheumatic Heart Disease*	Y	N
Diabetes	Y	N	Rheumatic Fever*	Y	N
Drug/Alcohol Abuse	Y	N	Stomach Problems	Y	N
Emphysema	Y	N	Stroke	Y	N
Epilepsy	Y	N	Tuberculosis	Y	N
Excessive Bleeding	Y	N	Venereal Disease	Y	N
Fen-Phen (fenfluramine/phentermine) Therapy*	Y	N	Other medical condition not listed, please explain: _____		
Heart Defect	Y	N			
Heart Valve Disease*	Y	N			
Hepatitis	Y	N	For Women:		
High Blood Pressure	Y	N	Currently pregnant	Y	N
HIV/AIDS	Y	N	If yes, how many weeks: _____		
Kidney Disease	Y	N	Taking birth control pills	Y	N

*(If yes to any of the starred conditions, premedication with an antibiotic may be necessary before treatment. Please call our office prior to your visit to find out if premedication is needed.)

Are you allergic to any of the following:

Acrylic	Y	N	Erythromycin	Y	N	Metal	Y	N
Aspirin	Y	N	Latex	Y	N	If yes, please explain: _____		
Codeine	Y	N	Penicillin	Y	N	Other drug/medicine not listed, please explain: _____		
Dental Anesthetics	Y	N	Tetracycline	Y	N			

List any drugs/medications you are presently taking: _____

Have you had any previous hospitalizations or surgeries: Y N
If yes, please explain: _____

Are you currently under the care of a physician? Y N
If yes, please explain: _____

List the name of your physician and phone number: _____

List the name and phone number of someone to notify in case of an emergency: _____

Authorization and Consent

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes. I hereby consent to and authorize the dental office to administer such medications and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I further understand that payment is due at the time of treatment unless prior arrangements have been made. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

Patient or Responsible Party Signature: _____

Date: _____

Office Use Only

I verbally reviewed the medical/dental information with the patient named herein.

Dentist Signature: _____ Date: _____