

*Thank you for trusting us with your dental care. We promise to do our best to provided you with the finest care available. If you have any questions please do not hesitate to call us.*

**PATIENT INFORMATION**

Name \_\_\_\_\_ Birthday \_\_\_\_\_ SS# \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F  Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered for \_\_\_\_\_ years

Home Phone # (\_\_\_\_) \_\_\_\_\_ Cell Phone #1 (\_\_\_\_) \_\_\_\_\_ Cell Phone #2 (\_\_\_\_) \_\_\_\_\_  
 Employer Phone # (\_\_\_\_) \_\_\_\_\_ Employer Name \_\_\_\_\_  
 Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone # (\_\_\_\_) \_\_\_\_\_  
 Person to contact in case of emergency \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

**RESPONSIBLE PARTY**

Name of person Relationship to Patient \_\_\_\_\_  
 Responsible for this account \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
 Address \_\_\_\_\_ Currently a patient in our office? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Birthdate \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
 Employer \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_  
 Email \_\_\_\_\_

**INSURANCE INFORMATION**

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Birthdate \_\_\_\_\_ SS# \_\_\_\_\_ Date Employed \_\_\_\_\_  
 Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
 Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union or Local # \_\_\_\_\_

**SECONDARY INSURANCE**

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Birthdate \_\_\_\_\_ SS# \_\_\_\_\_ Date Employed \_\_\_\_\_  
 Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
 Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union or Local # \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**HEALTHCARE PLAN**

## DENTAL HISTORY

Reason for today's visit \_\_\_\_\_ Date of last dental care \_\_\_\_\_

Former Dentist \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_

Address \_\_\_\_\_

## MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Lonimin, Adipex, Fastin (brand names of phentermine), Pndimin (fenfluramine) and Redux (dexfenfluramine).  Yes  No

Have you ever had any serious illnesses or operations?  Yes  No If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No If yes, give approximate dates \_\_\_\_\_

(Women) Are you pregnant?  Yes  No Nursing?  Yes  No Taking birth control pills?  Yes  No

Check if you have or have had problems with any of the following:

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Anemia                       | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> Arthritis, Rheumatism        | <input type="checkbox"/> Cough, Persistent    | <input type="checkbox"/> HIV/AIDS                  | <input type="checkbox"/> Sinus Problems             |
| <input type="checkbox"/> Artificial Joints, Pins, etc | <input type="checkbox"/> Cough up Blood       | <input type="checkbox"/> Jaw Pain                  | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Artificial Heart Valves      | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Kidney Disease            | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Liver Disease             | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> Back Problems                | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Mitral Valve Prolapse     | <input type="checkbox"/> Tobacco Habit              |
| <input type="checkbox"/> Bleeding Abnormally          | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Pacemaker                 | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Blood Disease                | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Psychiatric Care/Problems | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Cancer                       | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Radiation Treatment       | <input type="checkbox"/> Ulcer                      |
| <input type="checkbox"/> Chemical Dependency          | <input type="checkbox"/> Heart problems       | <input type="checkbox"/> Respiratory Disease       | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Chemotherapy                 | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Rheumatic Fever           |   |
| <input type="checkbox"/> Circulatory Problems         | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Scarlet Fever             |   |
| <input type="checkbox"/> Congenital Heart Lesions     | <input type="checkbox"/> Hernia Repair        | <input type="checkbox"/> Shortness of Breath       |   |

List any medications you are currently taking:

Allergies:

- |  |   |                                 |             |
|--|---|---------------------------------|-------------|
| <input type="checkbox"/> Aspirin                       | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Iodine | Other _____ |
| <input type="checkbox"/> Barbiturates (Sleeping Pills) | <input type="checkbox"/> Penicillin       | <input type="checkbox"/> Latex  | _____       |
| <input type="checkbox"/> Codeine                       | <input type="checkbox"/> Sulfa            | <input type="checkbox"/> None   | _____       |

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or in the above information.

**This information will be kept confidential.**

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print Name of Patient, Parent, Guardian, or Personal Representative

\_\_\_\_\_  
Relationship to Patient