Patient Information

(Confidential)

Name _____ Birth date _____ SS# _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Employer _____ Work Phone_____

Cell Phone_____

Spouse's Name _____

Person to Contact in Case of Emergency _____Phone_____

Name of your regular dentist_____

Who may we thank for referring you? _____

PAYMENT IS DUE AT THE TIME OF SERVICE

PLEASE CHECK THE PAYMENT OPTION YOU PREFER:

☐ Cash ☐ *Personal Check ☐ DISCOVER ☐ MC ☐ VISA ☐ AM EXPRESS ☐ Care Credit

*$30 fee for insufficient checks

Dental Insurance Information

Please note we ESTIMATE a copay- you are ultimately responsible for the entire fee

Insurance Company _____ Group #_____

Name of Insured _____ Relationship to Patient _____

SS# _____ Birthdate _____ Employee ID# _____

Name of Employer _____Work phone_____

Do you have secondary dental insurance?

Insurance Company _____ Group #_____

Name of Insured _____ Relationship to Patient _____

SS# _____ Birth date _____ Employee ID#_____

Name of Employer _____Work Phone_____

Patient Medical History

Medical Doctor _____ Date of Last Exam_____

ARE YOU UNDER MEDICAL TREATMENT OR HAVE YOU BEEN HOSPITALIZED WITHIN THE LAST 5 YEARS?

Please explain: _____

ARE YOU CURRENTLY TAKING ANY PRESCRIBED MEDICATION? Please include Aspirin

Please list: _____

_____

For Women Only:

	YES	NO
Are you pregnant or nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

ARE YOU ALLERGIC OR HAVE YOU HAD REACTIONS TO ANY OF THE FOLLOWING:

Dental Anesthetics	☐	☐
Penicillin	☐	☐
Sulfa	☐	☐
Codeine	☐	☐
Aspirin	☐	☐
Latex Rubber	☐	☐

Others, please list: _____

HAVE YOU HAD OR DO YOU PREMEDICATE FOR ANY OF THE FOLLOWING:

Rheumatic fever	☐	☐
Heart Murmur	☐	☐
Mitral Valve Prolapse	☐	☐
Heart Valve Replacement	☐	☐
Joint Replacement	☐	☐

PLEASE CHECK ALL THAT APPLY:

Heart Attack	☐	Alcohol/Drug Abuse	☐	Liver Disease	☐
Heart Disease	☐	Stroke	☐	Hepatitis/ Type	☐
Cardiac Pacemaker	☐	Fainting	☐	Thyroid Problems	☐
Chest Pains	☐	Epilepsy / Convulsions	☐	Arthritis	☐
Respiratory Problems	☐	Seizures	☐	Stomach Problems	☐
Asthma	☐	Cancer	☐	Recent Weight Loss	☐
Emphysema	☐	Radiation Therapy	☐	Glaucoma	☐
Easily Winded	☐	Anemia	☐	HIV or AIDS	☐
Tuberculosis	☐	Kidney Disease	☐	STDs	☐
High Blood Pressure	☐	Diabetes	☐	Seasonal Allergies	☐
Low Blood Pressure	☐	High Cholesterol	☐	Other (list below)	☐

Please list any others:_____