Personal Information

Name
I prefer to be called
Single Married Divorced Widowed
Male Female
Birthdate / / Age
SSN#
Street Address
Apt City
State Zip
Home Phone
Cell Phone
Email Address
Employer
Occupation
Work Phone
How did you hear about us?

Parent's Information *(if under 18)*

Mother Step Mother Guardian
Name Birthdate / /
Home/Cell Work
Employer
SS# DL#
Father Step Father Guardian
Name Birthdate / /
Home/Cell Work
Employer
SS# DL#

Dental Insurance

Primary Dental Insurance

Insurance Co. Name
Insurance Co. Address
Insurance Co. Phone
Group #
Member ID#
Insured's Name
Relation
Insured's Birthdate / /
Insured's SSN#
Insured's Employer
Health Insurance

Spouse Information

Name
Employer
Cell Work
Birthdate / /

Dental History

Who was your previous dentist?
When was your last dental visit?
When was your dental x-rays taken?
Are you currently sensitive or in pain?
Do you like your smile?
How many times a day do you brush?
How many times a week do you floss?

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. If my bill is placed in the hands of an attorney or collection agency for purposes of collection after default, I promise to pay all reasonable attorneys' fees and all other reasonable collection fees incurred. Furthermore, if a suit is instituted to enforce collection of my bill, I promise to pay all court costs associated with said legal action.

Our office policy is payment in full day of service. 5% discount is offered for cash or check. We accept Master Card and Visa. We also offer 3rd party no interest payment plans.

SIGNATURE **DATE**

SIGNATURE	DATE
______________________	__________
______________________	__________
______________________	__________
______________________	__________
______________________	__________

Medical History

Although dental personnel primarily treat your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Have you ever been informed to take a **pre-medication** before a dental appointment?	yes	no
Have you previously or currently been taking Bisphosphonates? *(ex: Alendronate, Fosamax, Zometa)*	yes	no
Are you under a physician's care now?	yes	no
If yes, please explain:		
Physician's Name: Number:		
Have you ever been hospitalized or had a major operation?	yes	no
If yes, please explain:		
Have you ever had a serious head or neck injury?	yes	no
If yes, please explain:		
Are you on a special diet?	yes	no
Do you use tobacco? How many daily? For how long?	yes	no
Are you taking any medications, pills, or drugs?	yes	no
If yes, please list:		

Are you allergic to any of the following: Aspirin Penicillin Codeine Latex Local Anesthetics Acrylic Metal Sulfa Tetracycline Others:

Do you have, or have you had any of the following?

Arthritis	Congenital Heart Disorder	Psychiatric Care
Emphysema	Epilepsy or Seizures	Mitral Valve Prolapse
Cancer	Excessive Bleeding	Pain In Jaw Joints
Asthma	Fainting/Dizziness	Radiation Treatments
Aids/HIV Positive	Heart Attack	Renal Dialysis
Artificial Heart Valve	Frequent Headaches	Recent Weight Loss
Artificial Joint	Heart Murmur	Rheumatic Fever
Ulcers	Heart Pace Maker	Hepatitis
Blood Transfusion	Hemophilia	Sinus Trouble
Tumors or Growths	Leukemia	Stroke
Chemotherapy	High Blood Pressure	Tuberculosis
Cold Sores/Fever Blister	Kidney Problems	Stomach/Intestinal Disease
Chest Pains	Liver Disease	
Diabetes	Lung Disease	

Women Only: Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Due Date / /

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.