Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as possible.
We look forward to working with you to maintainyour dental health.

Patient Information

Name________________________________ Soc. Sec. #_______________ Birthdate___________

Address_____________________________ City_____________ ST._____ Zip Code___________

Cell Phone_______________ Home Phone________________ Business Phone_____________

Email____

Sex __M __F __Single __ Married __ Widowed __Separated __ Divorced

Patient employed by_____________________________ Occupation_______________________

Business Address____

Business Email ____

Whom may we notify in case of emergency? _______________________________________

Relationship to Patient_____________________ Phone Number _______________________

Whom may we thank for referring you? ____

Primary Dental Insurance

Subscriber's Name________________________ Relationship to Patient__________________

Subscriber's Birthdate ___________________ Subscriber'sID #__________________

Insurance Company_______________________ Insurance Co. Phone #__________________

Group Name______________________________ Group # _________________________________

Subscriber Information. Fill out only if different from above.

Address_____________________________ City_____________ ST.______ Zip Code___________

Cell Phone_______________ Home Phone________________ Business Phone_____________

Subscriber Employed by_________________________ Occupation_______________________

Is the patient covered by additional insurance? ___yes ___no

Signature____________________________ Date_________________

Medical History

*Name*_________________________________*Date of Birth*__________________

Physician's Name____________________________**Phone**______________________

Date of last visit_______________ **Have you ever had any serious illnesses or operations? ___yes ___no**

Are you currently under physician care? ___yes ___no

If yes, describe____

Women: Are you pregnant? _____yes _____no Taking birth control pills? _____yes_____no

Check if you have or ever had any of the following conditions:

Aids/HIV positive		Dizziness		Other Medical	
Anemia		Emphysema		Pacemaker	
Anxiety Depression		Epilepsy		Periodontal Disease	
Arthritis		Glaucoma		Psoriasis	
Artificial Heart Valve		Headaches		Psychiatric	
Artificial Joints		Heart Attack		Radiation Treatment	
Asthma		Heart Disease		Respiratory Disease	
Back/Neck Problems		Heart Murmur		Shingles	
Cancer		Hemophilia		Sinus Problems	
Care Allergies		Hepatitis		Sleep Apnea	
Cataracts		Hiatal Hernia		Stents (arterial)	
Chemical Dependency		High Blood Pressure		Stroke Blood	
Chemotherapy		High Cholesterol		Swelling (feet or ankles)	
Circulatory Problems		Shortness of Breath		Thyroid Disease	
Colitis		Jaw Pain		Tobacco Habit	
Congestive Heart Failure		Kidney Disease		Tuberculosis	
Cough (persistent)		Liver Disease		Ulcers	
Diabetes		Migraines		Venereal Disease	
Disease Fainting		Mitral Valve Prolapse			

Other Medical Conditions____

Do you use a CPAP machine? ______yes ______no ____

Does patient have drug allergies? If yes, List all ____

Does patient need to premedicate with an antibiotic before dental treatment? ___yes ___no

If yes, for what condition?___________________________ **Name of Antibiotic**________________________

List any surgeries and dates____

Medications: Prescription &Over-the-CounterTaken for what condition

1.____

2.____ ____

3.____ ____

4.____ ____

5.____ ____

Signature____ **Date**____________________________