WELCOME

About You

Today's Date:_____

Name:_____

I prefer to be called:_____

Birth Date:_____ SS#:_____

Single Married Divorced Widowed Seperated

Home#:(_____)_____Cell#:(_____)_____

Mailing Address:_____

_____ZIP:_____

Home Address:_____

_____ZIP:_____

Email:_____

Employer:_____

How Long There?_____ Occupation:_____

Current Dentist:_____

SPOUSE INFORMATION

Spouse's Name:_____

Phone number: (___)_____

EMERGENCY CONTACT INFORMATION

Name:_____ Relationship:_____

Phone Number: (_____)_____

PERMISSION TO RELEASE MEDICAL AND FINANCIAL

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

PRIMARY DENTAL INSURANCE

**PLEASE PROVIDE PROOF OF INSURANCE*

*Insurance Co. Name:_____

*Insurance Co. Address:_____

*Group#:_____*Subscriber ID:_____

*Insured's Name:_____

*Relationship to Insured:_____

*Insured's Birthday:_____ SS#:_____

Secondary Dental Insurance

**PLEASE PROVIDE PROOF OF INSURANCE*

*Insurance Co. Name:_____

*Insurance Co. Address:_____

*Group#:_____*Subscriber ID:_____

*Insured's Name:_____

*Relationship to Insured:_____

*Insured's Birthday:_____ SS#:_____

MEDICAL HISTORY

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Y / N

Please explain:_____

Physicians Name:_____

Phone#:(____)_____Last visit date:_____

Are you taking any Prescription/over-the-counter drugs?

Please list each one (If you have a printed list please provide):

_____ _____

_____ _____

Have you ever had any of the following diseases or medical problems or conditions?

Y N Heart Attack
Y N Stroke
Y N Cancer/Chemotherapy
Y N HIV/Aids
Y N Pacemaker
Y N Mitral Valve Prolapse
Y N Kidney Problems
Y N Congenital Heart Defect
Y N Sinus Problems
Y N Psychiatric Problems
Y N Hepatitis A
Y N Hepatitis B
Y N Hepatitis C
Y N Tuberculosis
Y N Epilepsy
Y N Radiation Treatment
Y N Fainting Spells
Y N Drug/Alcohol Abuse
Y N Ulcers
Y N Colitis
Y N Seizures
Y N Asthma
Y N High Blood Pressure
Y N Low Blood Pressure
Y N Diabetes
Y N Artificial Bones / Joints / Valve Date:_____

Are you required to premedicate for this visit? Y / N

Please indicate any serious medical conditions or hospitalizations you have ever had:

_____

Are you allergic to any of the following?

Y N Penicillin
Y N Aspirin
Y N Codiene
Y N Sulfa
Y N Latex
Y N Dental Anesthetics
Y N Tetracycline
Y N Erythromycin

Please list any other drug allergies:

_____

FOR WOMEN: Are you taking birth control pills? Y / N

Are you pregnant? Y / N Due Date: _____

Are you nursing? Y / N