Date _____
Patient Name_____
Date of Birth _____ Patient SS#_____
Address _____Apt.#_____Box#_____
City _____ State _____ Zip _____
Home Phone # _____ Cell Phone # _____
e-mail _____
Name of relative (not living with you) _____
Address _____ Apt.#_____Box#_____
City _____ State _____ Zip _____
Phone # _____ Relationship _____
Patient employed by_____
Address _____Box #_____
City _____ State _____ Zip_____
Work Phone # _____

If the Patient is a minor, please list responsible party
Name _____
Date of Birth _____ SS# _____
Address _____ Apt # ____Box# ____
City _____ State _____ Zip _____
Home Phone # _____
Cell Phone # _____
Relationship to Patient _____

Primary Insurance Company_____
Employer _____
Cardholder's Full Name _____
Birthdate of Cardholder _____
Relationship to Patient _____
Identification # _____

Secondary Insurance Company_____
Employer _____
Cardholder's Full Name _____
Birthdate of Cardholder _____
Relationship to Patient _____
Identification # _____

Office Policy

We are here for your dental needs and we want you to be comfortable. Please feel free to ask any questions you may have. Payment is due when services are rendered. If you have dental insurance, we will be happy to submit your insurance claim as a courtesy, however it is important for you to remember that you are responsible for your account. Accounts over 60 days will be charged 1.5% interest monthly.

Signature_____
Relationship if signing for a minor _____Date _____

Medical History

Please answer each question

	Yes	No
Heart Murmur	☐	☐
Heart Problems	☐	☐
Heart Valve Replacement	☐	☐
Pacemaker	☐	☐
Valvular Disease	☐	☐
High or Low Blood Pressure	☐	☐
Stroke	☐	☐
Bleeding tendency/disorder	☐	☐
Diabetes	☐	☐
Rheumatic Fever	☐	☐
Hepatitis	☐	☐
Kidney disease	☐	☐
Respiratory problems	☐	☐
T.B.	☐	☐
Do you use tobacco in any form	☐	☐
Epilepsy	☐	☐
Artificial joints or prosthetics	☐	☐
Do you have AIDS	☐	☐
Are you HIV Positive	☐	☐
Are you recovering from alcohol/drug addiction	☐	☐
Are you presently taking oral contraceptives	☐	☐
Are you pregnant	☐	☐
Are you taking any prescribed or over the counter medications	☐	☐

Please list all medications:

_____
_____
_____
_____

Are you sensitive to metals or latex ☐ ☐

Do you have any disease, condition or problem not listed? If so, explain

_____
_____

Is there anything else we should know about your health that we have not covered in this form?

_____
_____

		Yes	No
Allergies	Penicillin	☐	☐
	Codeine	☐	☐
	Anesthetics	☐	☐
	Sulfa	☐	☐

Other _____

Physicians Name _____
Address _____
City_____state___Zip_____
Phone # _____