

Patient Information

Patient Name _____ Today's date _____

Gender(M/F) ___ Marital Status _____ Birth Date _____ Social Security # _____

Driver's License # _____ E-mail Address _____

Address _____

Street

Apt #

City

State

Zip Code

Phone #'s Home _____ Work _____ Ext _____ Best time to call _____

Fax _____ Pager _____ Other _____

Name of person, office or other source referring you to our practice _____

Spouse or Responsible Party Information

Name: _____

Gender(M/F) ___ Marital Status _____ Birth Date _____ Social Security# _____

Driver's License # _____ E-mail Address _____

Address _____

Street

Apt

City

State

Zip Code

Phone #'s Home _____ Work _____ Ext _____ Best time to call _____

Fax _____ Pager _____ Other _____

Employment Information

The following is for: ___ the patient ___ the person responsible for payment

Employer Name _____

Address _____

Street

City

State

Zip Code

Phone

Insurance Information

Name of Insured _____

Insured's Birth Date _____ ID# _____ Group # _____

Insured's Employer Name _____

Patient's relationship to insured ___ Self ___ Spouse ___ Child ___ Other

Insurance Plan Name and Address _____ (OVER)

Health History

Are you under the care of a physician? ___yes ___no

If so, physician's name _____ Phone# _____

Emergency Contact _____
 Name Relationship Phone #

Are you taking any prescription/over-the-counter drugs? ___yes ___no

Please list each one _____

For Women: Are you taking birth control pills? ___yes ___no

Are you pregnant? ___yes ___no Are you nursing? ___yes ___no

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

	NO	YES		NO	YES
Heart Attack/Stroke			Artificial Joints		
Heart Murmur			Hemophilia/Abnormal Bleeding		
Rheumatic Fever			Cancer/Chemo-radiation Therapy		
Mitral Valve Prolapse			Ulcers		
Artificial Heart Valves			Diabetes		
Heart Surgery/Pacemaker			Epilepsy/Seizures/Fainting Spells		
High/Low Blood Pressure			Drug/Alcohol Abuse		
Severe/Frequent Headaches			Hospitalized for Any Reason		
Asthma/Bronchitis			Drug Allergies		
Emphysema/Tuberculosis			Latex Allergies		
Hepatitis					

Any other problems or diseases not listed above? _____

Comments _____

Annual Medical history review: _____

DOCTORS USE ONLY

CONSENT, AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay the dentist any insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance transmissions.

Signed _____

Date _____