Patient Information:

First Name:______________________ Last Name:_________________________

Middle Initial:_________

By what name do you wish to be called? _________________________________

Street Address:____

City & State:_________________________________ Zip Code:______________

Home Phone:___________________ Work Phone:___________________

Cell Phone:_____________________ E-mail:________________________

How do you prefer to be contacted? _____________________________

Employer:____

Marital Status (circle): Married Single Child Other

Gender (circle): Male Female

Date of Birth: Month__________ Day_______ Year___________

Responsible Party (*circle*): Self Other

If Other, please specify:

Name:____

Relationship:__________________

How did you first learn about us?____

Is there someone we may thank for referring you to us?____________

If so, who?____

Is there anything you would like us to know about you so we can serve you better?

____

____

____

Insurance Information:

Primary Insurance:

Patient's Relationship to the Subscriber (*circle*): Self Spouse Dependant Other

Subscriber's Name:____

Primary Insurance #:___________________________

Group #:______________________________

Patient's Social Security #:_____________________________

Subscriber's Social Security #:_______________________________

Emergency Contact Information:

Contact Person:____________________________ Relationship:_____________

Phone:________________________ Other Phone:___________________

Medical History:

Primary Care Physician:____

Phone:_______________________

Allergy to:

(Circle all the following that apply)

Aspirin Barbituates Codeine

Penicillin Sulfa Local Anesthetic

Iodine Latex Other (specify):

____

Conditions (past or present):

(Circle all the following that apply)

Anemia	Arthritis	Artificial Heart Valve	Asthma
Back Problems	Bleeding Abnormally	Blood Disease	Cancer
Chemical Dependency	Chemotherapy	Circulatory Problems	Diabetes
Congenital Heart Lesions	Cortisone Treatments	Frequent Coughing	Epilepsy
Fainting	Glaucoma	Headaches	Heart Problems
Heart Murmur	Hemophilia	Hepatitis	Hernia Repair
High Blood Pressure	HIV/AIDS	Jaw Pain	Kidney Disease
Liver Disease	Mitral Valve Prolapse	Osteoporosis	Pacemaker
Radiation Treatment	Respiratory Disease	Rheumatic Fever	Scarlet Fever
Shortness of Breath	Skin Rash	Stroke	Tonsillitis
Swelling of Feet or Ankles	Thyroid Problems	Tobacco Habit	Tuberculosis
Ulcer	Other (specify):____		

Medications:

List all medications you are currently taking:

Medication:	Dosage:	Purpose:
___________________________	___________________________	_________________
___________________________	___________________________	_________________
___________________________	___________________________	_________________
___________________________	___________________________	_________________
___________________________	___________________________	_________________

_________________________ _________________________ ________________

_________________________ _________________________ ________________

_________________________ _________________________ ________________

_________________________ _________________________ ________________

If you have more, please continue the list at the bottom of this page.

Have you ever been told that you need pre-medication before certain dental procedures?____________

Is there anything else you would like for us to know about your health?

____

____

____

Thank you. We are looking forward to meeting you!