Patient_____ _____ _____ _____

Last Name **First Name** Initial Preferred Name

Street Address _____

City _____ **State** _____ **Zip** _____ **Home Phone**_____

Cell Phone _____

Sex: M F Age _____ **Birthdate** _____

Social Security Number _____

Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Spouse's Name _____ Spouse's Birthdate _____

Spouse's Employer _____ Spouse's ss# _____

Business Address _____ Business Phone _____

Name of person responsible for this account?_self/other _____

Name of Dental Insurance Company _____ Group Number _____

In case of emergency, who should be notified? _____ Phone _____

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? ……Yes No
   If yes, for what? _____
   Physician's Name _____ Phone _____
2. Are you taking any medication, drugs, ***aspirin*** or pills now? ……..….Yes No
   If yes, please list name and dosage _____
3. Are you aware of having an allergic reaction to any medication or substance? ……Yes No
   If yes, please list _____
4. Have you been a patient in the hospital during the past five years? …… Yes No
5. Indicate which of the following you have at present. Circle "yes" or "no" to each item.

Heart (surgery, disease, attack)….Yes No	Ulcers……..Yes No	Venereal Disease……Yes No
Chest Pain……..Yes No	Diabetes …… Yes No	A.I.D.S. …… Yes No
Congenital Heart Disease …….Yes No	Thyroid Problems ……...Yes No	HIV Positive ……....Yes No
Heart Murmur ……...Yes No	Glaucoma …… ..Yes No	Cold Sores/Blisters……....Yes No
High Blood Pressure ……Yes No	Emphysema ……Yes No	Blood Transfusion ……....Yes No
Mitral Valve Prolapse ……Yes No	Chronic Cough ……...Yes No	Hemophilia ……..….Yes No
Artificial Heart Valve ……Yes No	Tuberculosis …….. Yes No	Sickle Cell Disease ……...Yes No
Heart Pacemaker ……Yes No	Asthma ……...Yes No	Bruise Easily ……..…Yes No
Rheumatic Fever ……Yes No	Hay Fever ……..…..Yes No	Liver Disease ……Yes No
Arthritis/Rheumatism …….Yes No	Allergies or Hives ……..…..Yes No	Yellow Jaundice ……Yes No
Cortisone Medicine ……Yes No	Sinus Trouble …….Yes No	Neurological Disorder ……..Yes No
Stroke ……Yes No	Radiation Therapy ……..Yes No	Epilepsy or Seizures …….. ..Yes No
Diet (Special/Restricted) ……Yes No	Chemotherapy …… Yes No	Fainting or dizziness …….Yes No
Artificial Joints (hip, knee, etc.) ….Yes No	Tumors ……Yes No	Nervous/Anxious ……..Yes No
Kidney Trouble ……...Yes No	Hepatitis A or B ……..…… Yes No	Psychiatric/Psychological Care…….Yes No

6. Are you a smoker? …….. Yes No
   If yes, how much do you smoke a day? _____
7. Have you lost or gained more than 10 pounds in the past year? …… Yes No
8. Do you have or have you had any disease, condition or problem not listed? ……. Yes No
   If yes, please list _____
9. Women, Are you: Pregnant? Yes ___ Months No Nursing? Yes No Taking Birth Control Pills? Yes No

How will you be paying for your treatment? -check -cash -M/C-VISA-Discover-A/E-CareCredit

Who is your general dentist? _____Phone_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing insurance for benefits for which I am entitled. I will not hold my dentist or any other member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient/Guardian Signature _____ Date_____