WELCOME TO OUR OFFICE

DATE:_____

PATIENT INFORMATION

Name_____Date of Birth_____SS#_____

Street Address_____City_____State_____Zip_____

HomePhone_____WorkPhone_____CellPhone_____

e-mail address:_____ Marital Status_____ In The Military? (Y / N)

Employer's Name/Address_____

Emergency Contact_____Phone#_____

Do you have any Dental Insurance that will help pay for your visit?_____If yes, complete the Ins. Infor Sheet

RESPONSIBLE PARTY

Name_____Date of Birth_____SS#_____

BillingAddress_____City_____State_____Zip_____

Home Phone_____Work Phone_____Cell Phone:_____

e-mail address:_____Marital Status_____In The Military? (Y/N)

I was referred by_____ I will be paying today by: Cash Check Visa/MC

PATIENT MEDICAL HISTORY

Physician's Name_____Phone #_____Date of Last Exam_____

	Yes	No		Yes	No		Yes	No
Heart Condition from Birth..			Asthma or Lung Disease….			Chest Pains…….		
Hist of Bacterial Endocarditis…			Jaundice or Hepatitis….....			Stroke……..		
Heart or Heart Valve Surgery			Anemia…….			Radiation/Chemo Therapy….		
Artificial Prosthesis…….....			Prolonged Bleeding…….			Thyroid Problem……		
High/Low Blood Pressure….			Are you taking a blood thinner			Latex Allergy…….		
Glaucoma or Diabetes……			AIDS or HIV Infection.....			Allergy to any metals…….		
Epilepsy…….			Do you use tobacco……..			Stomach Troubles/Ulcers…...		
Cancer……			Ever taken Fen-Fen/Redux..			Liver Disease……..		

Additional Notes:_____

_____

Are You **Allergic** to Any Medications?_____

Any Other Health or Dental Related Problems?_____

_____

List Any **Drugs/Medications** you are presently taking (Including Birth Control)_____

_____

List Any **Dental Concerns** you want us to address_____

_____Date of Last Exam_____

_____Date_____

Patient or Parent's Signature