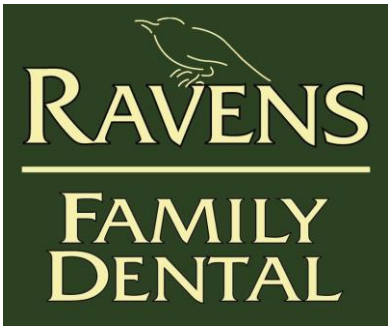

PATIENT INFORMATION

(Circle One) Mr. Mrs. Ms. Miss Dr. _____ _____
(First Name) *(Last Name)*

Address: _____
(Street Address) *(City)* *(State)* *(Zip Code)*

Phones: _____
(Home) *(Cell)* *(Work)*

Email: _____

Whom may we thank for referring you? _____

Other family members who are patients here: _____

Date of Birth: _____ Sex: _____ Marital Status: Single Married Divorced Widowed

Employer: _____ Occupation: _____

Employer's Address: _____
(Street Address) *(City)* *(State)* *(Zip Code)*

Emergency Contact: _____
(Name) *(Relationship)* *(Phone)*

MEDICAL HISTORY

Physician's Name: _____ Phone: _____

Physician's Address: _____
(S*treet Address)* *(City)* *(State)* *(Zip Code)*

Please circle if you are allergic to: Latex Codeine Dental Anesthetics Metals/Jewelry

Are you allergic to any antibiotics? YES NO Please list: _____

Please list any other drug allergies you may have: _____

Did your doctor tell you that you need to pre-medicate prior to dental treatment? YES NO

List all medications you are currently taking (including inhalers and birth control): _____

_____

Are you Diabetic? YES NO

Do you have High Blood Pressure? YES NO

Please list any heart conditions you have been treated for in past or present: _____

_____

Do you have any artificial joints? Yes NO Please explain: _____

Have you ever had a chemical dependency? Yes NO Please explain: _____

Do you have a tobacco habit? YES NO Which type: _____

For Women: Are you pregnant? YES NO POSSIBLY Are you nursing? YES NO

Please list all other medical conditions or diseases you have or have had in the past: _____

_____

DENTAL HISTORY

Why have you sought dental care? _____
Do you have dental pain? YES NO SOMETIMES
Are you satisfied with the condition of your teeth/smile? YES NO
Do your gums bleed? YES NO
How many times do you floss per day_____ and brush per day_____?
What type of toothbrush do you use? SOFT HARD ELECTRIC
Previous Dentist's Name: _____ Date of last cleaning: _____

PRIMARY DENTAL INSURANCE

Subscribers name: _____ Relationship to you: _____
Subscriber's SS#: _____ Subscriber's date of birth: _____
Patient's SS# (if patient is not subscriber): _____
Address (if different from patient): _____
(Street Address) (City) (State) (Zip Code)
Subscriber's Employer: _____
Employer's Address: _____
(Street Address) (City) (State) (Zip Code)
Plan Name: _____ Group #: _____
Insurance Company: _____ Insurance Phone: _____
Insurance Address: _____
(Street Address) (City) (State) (Zip Code)

SECONDARY DENTAL INSURANCE

Subscribers name: _____ Relationship to you: _____
Subscriber's SS#: _____ Subscriber's date of birth: _____
Address (if different from patient): _____
(Street Address) (City) (State) (Zip Code)
Subscriber's Employer: _____
Patient's SS# (if patient is not subscriber): _____
Employer's Address: _____
(Street Address) (City) (State) (Zip Code)
Plan Name: _____ Group #: _____
Insurance Company: _____ Insurance Phone: _____
Insurance Address: _____
(Street Address) (City) (State) (Zip Code)

AUTHORIZATION

I have reviewed the information on this questionnaire to assure it is accurate to the best of my knowledge. I understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental service that I may need with my informed consent. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.
Signature: _____ Date: _____