PATIENT INFORMATION

Name:_____ SS#_____-___-_____ Birthdate____-___-____

Male___ Female___ I prefer to be called:_____

Marital Status: Single___ Married___ Seperated___Divorced___Widowed___

Home #____-____-_____ Cell or Pager____-____-_____ E-mail Address_____

Home Address_____ City_____State____Zip Code___

Referred By?_____ When and where is the best time to reach you?_____

Employer:_____Occupation:_____ How long there?_____

Employer Address_____Work #____-____-___

Person responsible for account_____ SS #_____-____-_____

Person to call in case of an emergency_____Phone #_____-_____-_____

DENTAL INSURANCE

Insurance Co. Name:_____ Insurance Co. Address:_____

Group # (Plan, Local or Policy #):_____Insurance Co. Phone #_____-_____-_____

Insured's Name:_____ Relation:_____ Insured's Birthdate:____/____/__

Insured's SS#_____-____-_____ Insured's Employer:_____

MEDICAL HISTORY

Physician's Name_____
Address_____
Physician's Phone #_____-_____-_____ Last Visit Date:_____
Your current physical health is? Good____ Fair____ Poor____

Have you ever had any of the following?

Y N Heart Attack/Stroke	Y N Kidney Problems	Y N Anemia
Y N Cancer_____	Y N Jaundice/Liver Problems	Y N HIV/AIDS
Y N Heart Murmur	Y N Diabetes	Y N Hepatitis
Y N Rheumatic Fever	Y N Tuberculosis	Y N Arthritis
Y N Mitral Valve Prolapse	Y N Thyroid Problems	Y N Drug/Alcohol Problems
Y N Joint/Heart Valve Replacement	Y N Stomach/Intestinal Problems	Y N Asthma
Y N Any Heart Abnormalities	Y N Epilepsy/Convulsions/Seizures	Y N Severe/Frequent Headaches
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Sinus Problems
Y N Abnormal Bleeding/Bruising		

List any other Health Problems:_____

Are you allergic to any of the following drugs?

Y N Penicillin	Y N Tetracycline	Y N Dental Anesthetics (Novocain)
Y N Aspirin	Y N Sulfa Drugs	Y N Other, Please List:_____
Y N Eyrthromycin	Y N Codeine	

Please list any presciption/over the counter drugs you are currently taking:_____

WOMEN ONLY
Y N Are You Pregnant? Week #____
Y N Are You Taking Birth Control Pills?
Y N Are You Nursing?

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENT HAVE BEEN

Patient, Parent or Guardian Signature_____Date_____