Today's Date: _____

Name: _____
Last First

I prefer to be called: _____

Birthday: ___/___/___ Age: _____

SS#: _____

Home Address: _____

_____Zip Code: _____

()Single ()Married ()Divorced
()Widowed ()Separated

()Male ()Female

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

Employer: _____

Employer's Address: _____

_____ Zip Code: _____

Email Address: _____

How did you hear about us? _____

_____

Other family members seen by us: _____

_____

SPOUSE INFORMATION:

Name: _____

Employer: _____

Work Phone#: _____

SS#: _____

Birthdate: _____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, CDC and the ADA, therefore there will be a sterilization barrier protection fee charged per visit.

PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

Group/Plan #: _____

Insured's Name: _____

Relationship:_____

Insured's Birthday: ___/___/___

Insured's SS#: _____

Insured's Employer: _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

Group/Plan #: _____

Insured's Name: _____

Relationship: _____

Insured's Birthday: ___/___/___

Insured's SS#: _____

Insured's Employer: _____

IN THE EVENT OF AN EMERGENCY, who should we contact: _____

Relationship: _____

Phone #'s: _____

I understand that the information that I have given today is correct to the best of my knowledge. It is understood 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 services with my informed consent that I may need during diagnosis and treatment.

If this account is placed for collection, the patient agrees to pay all collection fees or court costs and attorneys fees.

Payment is due in full at the time of treatment unless prior arrangements have been approved.

_____
Signature Date

MEDICAL HISTORY

Have you been under the care of a medical doctor during the past two years? Yes No
If so, for what condition? _____

Doctor's Name	Treatment	Date

List all medications taken in the last six months: _____
_____

Are you sensitive or allergic to any medicines? (penicillin, aspirin, codeine, iodine, erythromycin, tetracycline, epinephrine, cephalosporins, clindamycin) Others: _____
_____

Are you sensitive or allergic to any metals?		Yes	No
Women only:	Are you pregnant?	Yes	No
	Do you anticipate becoming pregnant?	Yes	No
	Are you taking birth control pills?	Yes	No

Has a physician ever told you that you need to be pre-medicated prior to dental treatment, due to a medical condition? Yes No

Please circle any of the following conditions which you have been diagnosed with by a physician

Heart Murmur
Rheumatic Fever
Mitral Valve Prolapse
Artificial Heart Valve
High or Low Blood Pressure_____
Heart Failure
Heart Disease or Attack
Angina Pectoris
Heart Pacemaker
Heart Surgery, when _____
Liver Disease
Kidney Trouble
Excessive Bleeding
Hepatitis
Jaundice
GI Disorder

Do you clench or grind your teeth? ____

Would you like to improve the appearance of your smile? _____
If so, what would you like to change?
_____

Artificial Joints
Cancer or Tumor, if so type _____
Chemotherapy or Radiation Therapy, Date of Last Treatment _____
Anemia
Epilepsy or Seizures
Emphysema
Tuberculosis
AIDS, HIV, or ARC
Diabetes
Ulcers
Asthma
Sinus Trouble
Thyroid Disease
Arthritis
Psychiatric treatment (ex: depression, anxiety...)
Hemophilia
Sleep Apnea/Snoring
Organ Removal or Transplant, if so which one _____
Glaucoma
Prostate/Urinary Tract
Temporomandibular Dysfunction (TMJ)

To the best of my knowledge, all of the preceding answers are true and correct. If I have any changes in my health or medications, I will notify my dentist at the next appointment.

_____ _____ _____
Signature of Patient, Parent, Guardian Date Signature of Dentist

Medical History Update:

_____
_____
_____
_____
_____