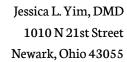


Welcome to our office! We would like to get to know you better. Please fill out this form as completely as you can.

Patient Information

Name:		Preferr	ed Name:			
D.O.B	Gender:	Marita	l Status:			
S.S.N	Driver's License #:					
Street Address:		Apt./U	Jnit:			
City:	State:	ZIP:				
Mobile phone:	Home phone:	Email:				
Can we contact you through email or text? Yes No						
How did you hear about our office? (If there was a personal referral, pleas Dental History	e provide their name so we can thank t	hem!)				
Reason for today's visit?	Last de	ntal visit	?			
Have you ever had any serious problems with dental treatment? Do you feel discomfort in any of your teeth? Do your teeth bleed when you brush or floss? Do you have joint/jaw pain? How often do you brush daily? Floss?		Yes Yes Yes Yes	No No No			
Any other dental questions or conc	erns that have not been covered abo	ove?				





Insurance Information

Name of Insured:	Relationship to Patient:
D.O.B Occupation:	Employer:
Group #:	ID#/SSN:
Dental Insurance:	
Secondary coverage? Y / N	
Name of Insured:	Relationship to Patient:
D.O.B Occupation:	Employer:
Group #:	ID# / SSN:
Assignment and Release	
benefits, if any, otherwise payable to me for services re	we insurance coverage and assign directly to <i>Dental On 21st</i> all insurance endered. I understand that I am financially responsible for all charges the doctor to release all information necessary to secure the payments of urance submissions.
Our office complies with all federal HIPAA regulation available upon request.	s regarding privacy of patient information. A copy of privacy policies is
Financially Responsible Party Name:	Relationship to Patient:
Signature:	Date:



Patient Name: _____

Medical History

Heart attack or heart problems Ye Congenital heart disease Ye		No		Fainting or blackouts	Yes	No No
		No		Digestive disorder	Yes	
Chest pain with exercise (angina)	Yes	No		Asthma	Yes	No
High blood pressure	Yes No		Stroke or stroke history		Yes	No
Heart valve disorder	Yes	No	No Drug or alcohol dependency		Yes	No
Pacemaker	Yes	No		Kidney or liver problem	Yes	No
Psychiatric disorders	Yes	No		Cancer, tumors or radiation	Yes	No
Implant or artificial joint	Yes	No		Osteoporosis or osteopenia	Yes	No
Diabetes	Yes	No		Headaches or migraines	Yes	No
Anemia or blood disorder Ye		No	No	Epilepsy or seizures	Yes	No
Ulcers, reflux or heartburn	Yes	No		AIDS or HIV infection	Yes	No
Thyroid disease	Yes	No		Tuberculosis or lung problems	Yes	No
Excessive bleeding	Yes	No		Hepatitis A, B, C, or D	Yes	No
Please explain any conditions marked "Yes" above	2:					
Are you pregnant? Are you breastfeeding?		Yes Yes	No No	If yes, when are you due?		
		37	No	If yes, how many per day?		
Do you smoke?		Yes	INO	11 yes, now many per day:		



Medical History

Patient Name:			
Physician's name and phone:		-	
Have you ever had an allergic reaction to a drug such as penicillin,	sedative, latex, aspirin, or metals?	Yes	No
If yes, please describe the reaction:			
$Please\ list\ all\ prescription\ or\ over-the-counter\ drugs,\ medications$, or vitamins you are currently taking, o	r write "]	NONE." If
you carry a list of medications, please provide us a copy.			
Responsible party (print):	Relationship (if other):	-	
Signature:	Date:		