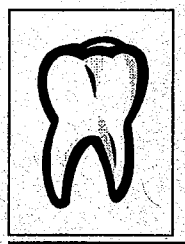

PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name _____ Preferred name _____ Birth date _____

If minor, parents names _____ Preferred phone _____ Work phone _____

Mailing address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____ ❑ Unmarried

EmailAddress_____ **Emergency Contact Name and Phone Number**_____

BILLING AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Dental Insurance Co._____ Group # _____ Your Social Security # _____

Insurance ID # _____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company _____ Group number _____

Spouse's birthday _____ Social Security # _____ Insurance ID # _____

****

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you ***allergic*** to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you ***taking*** any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

****

PLEASE COMPLETE BOTH SIDES

Name of your physician:_____ Phone # _____

Do you have any disease, condition, or problem not listed above?_____

_____

Please add anything else you would like us to know about:_____

_____

_____

_____

Please indicate any serious illnesses or operations_____

_____

****

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay 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 of benefits. I understand that I am financially responsible for all the charges whether or not paid by insurance.

Signature of patient (or parent) _____ Date _____

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