Patient Name: ______________________________ *Preferred* ________ *Date:* ________
Last *First* *MI*

Gender: ______________ *Family Status:* ____________ *Birth Day:* ___/___/___

Social Security #: ______/___/______ *Drivers License* ____________________

Work Phone#: _(___)____-________

Home Phone #: _(___)_____-______ *Cell #:* _(___)____-______

Address: ____ *Apt #* _______
Street

____
City *State* *Zip Code*

E-Mail address ____________________________________

How did you hear about our office? __________________________

Are you happy with your smile? ____________________________

Do you have any dental concerns or complaints? ____________________

A 48 hour notice MUST be given for cancellations or a $35 charge will be added to your account. (Initial _____)

Payment in FULL is expected at time of service unless prior arrangements have been made. (Initial _____)

We provide an insurance ESTIMATE for patients, we want to clearly explain that we are providing a benefit to our patients by accepting the insurance payment and that the fee is the sole responsibility of the patient. (Initial _____)

Primary Insurance Information
Name of Insured: ____________________________ *Is insured a patient?* *Yes or No*
Last *First*
Insured's Birth Date: ____/___/____ *ID#:* ___________ *Group#:* _______

Insurance Plan Name and Phone No. ____________________________
Insured's Employer Name: ____________________________________
Patient's relationship to insured: ____ *Self* ____ *Spouse* ____ *Child* ____ *Other*

Medical History

1. *Have you been under the care of a medical doctor during the past two years?*.. *Yes No*
   If yes, for what? ____________________
   Physician's Name ____________________ *Phone* ____________

2. *Are you currently taking any medication or drugs, including regular doses of aspirin or herbal medicines?* *Yes No*
   If yes, please list: ____________________
   ____

3. *Are you aware of having any allergic (or adverse) reaction to any medication or substance?*.......................... *Yes No*
   If yes, please list: ____________________

4. ***Have you been advised by your doctor to take antibiotics prior to dental treatment?*** .... *Yes No*

5. *Have you ever been treated for gum disease or told you may have it?*.. *Yes No*

6. *Have you been a patient in the hospital during the past five years?*.. *Yes No*

7. *Indicate which of the following you have had or have presently. Circle "yes" or "no" to each item.*

Heart (surgery, disease, attack)	*Yes*	*No*	*Latex Sensitivity*	*Yes*	*No*	*Hepatitis A B C (circle)*	*Yes*	*No*
Abnormal Heart Condition	*Yes*	*No*	*Artificial Joints*	*Yes*	*No*	*Venereal Disease*	*Yes*	*No*
Congenital Heart Disease	*Yes*	*No*	*Liver Disease*	*Yes*	*No*	*Epilepsy or Seizures*	*Yes*	*No*
Heart Murmur(MVP)	*Yes*	*No*	*Slow healing mouth sores*	*Yes*	*No*	*H.I.V. Positive/AIDS*	*Yes*	*No*
High Blood Pressure	*Yes*	*No*	*Sore Lymph Nodes*	*Yes*	*No*	*Cold Sores/Fever Blisters*	*Yes*	*No*
Diabetes	*Yes*	*No*	*Previous Biopsies*	*Yes*	*No*	*Fainting or Dizzy Spells*	*Yes*	*No*
Artificial Heart Valve	*Yes*	*No*	*Emphysema*	*Yes*	*No*	*Abnormal Bleeding*	*Yes*	*No*
Kidney Trouble	*Yes*	*No*	*Tuberculosis*	*Yes*	*No*	*Nervous/Anxious*	*Yes*	*No*

7. *Do you have or have you had any disease, condition, or problem not listed?* .... *Yes No*
   If yes, please list: ____________________

8. *Cancer: Yes or No; What kind?*____________________*Type of Tx. (Radiation/Chemo) When?*______

9. *Have you or are you currently, taking* ***Bisphosphanates*** *(Fosamax, Actonel, Boniva, etc)*......................... *Yes No*

10. *Are you taking* ***blood thinners*** *(Plavix, Coumadin, Warfarin,etc.)*.. *Yes No*

11. *Have you or are you currently using tobacco products'?* ... . *Yes No*

12. *Women: Are you pregnant or think you may be pregnant? Yes,* ______ *Months No Nursing?* *Yes No*

13. *Women: Do you use birth control medications?*.. *Yes No*

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist of any changes in my health or medication.

Patient/Guardian Signature ______________________________ *Date*______________