Patient Information

Name _____ Soc. Sec. # _____-_____-_____
Last, First, Middle Initial

Phone: Home (_____) _____ Work (_____) _____ Cell (_____) _____

Sex: __ Male __ Female Birth Date_____/_____/_____ __ Single __ Married __ Widowed

Address _____ City _____ State _____ Zip_____

Employer_____ Occupation _____

Spouse's Name _____ Email Address _____

Referred to this office by _____

Dental Insurance

Insurance Company _____ Insurance Phone (_____) _____

Subscriber name _____ Subscriber SS # _____-_____-_____

Group # _____ Coverage: Self Family Subscriber Birthdate:_____

Person Responsible for Payment

Name _____ Soc. Sec. # _____-_____-_____

Relationship_____ Employer_____ Occupation_____

Address _____ City _____ State _____ Zip_____

Phone (_____)_____ Drivers Lic # _____ State_____ Exp Date_____

Medical History

Physician's name _____ Phone (_____) _____ Last visit _____

Address _____ City _____ State _____ Zip _____

Have you been hospitalized in the past 5 years? _____ Reason _____

Have you had a joint replacement and/or stint placed? _____

Have you had any serious illnesses or operations? yes no If yes, _____

Are you pregnant? yes no Do you smoke? yes no

Please list any medications you are currently taking _____

Do you have or have you had any of the following? Please circle Yes or No:

Heart disease	Yes	No	Hemophilia/ abnormal bleeding	Yes	No
High Blood Pressure	Yes	No	Tumor History	Yes	No
Blood Disorder–Anemia	Yes	No	Venereal Disease	Yes	No
Rheumatic Fever	Yes	No	Sinus Trouble	Yes	No
Heart Murmur	Yes	No	Ulcer	Yes	No
Thyroid disease	Yes	No	Radiation Treatment	Yes	No
Hyperthyroidism	Yes	No	Liver/Kidney Disease	Yes	No
Diabetes	Yes	No	Hepatitis/Jaundice	Yes	No
Stroke	Yes	No	Aids/HIV +	Yes	No
Epilepsy, Fainting	Yes	No	Asthma	Yes	No
Psychiatric Treatment	Yes	No	Tuberculosis	Yes	No
Arthritis	Yes	No	Emphysema	Yes	No

Are you allergic to any of the following? Please circle:

Aspirin Codeine Local Anesthetic Novocain Erythromycin Penicillin Jewelry/Metals Latex

List other drugs/materials you are allergic to _____

Emergency Contact

In case of emergency, who should we contact?

Name_____ Relationship _____ Phone (_____) _____

Address _____ City _____ State _____ Zip_____