PERSONAL INFORMATION:

Today's Date: _____

Patient's Name _____ Sex: M/F _____ Age _____ Birthdate _____

Home Address: _____ City _____ State _____ Zip _____

Mailing Address: _____ City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____ Social Security # _____

Employer _____ Employer Address _____ Bus. Phone # _____ Ext. _____

Spouse _____ Spouse Employer _____ Spouse Work Phone _____ Ext. _____

If Patient is a Minor, Complete Below

Parent/Guardian _____ Social Security# _____ Birthdate _____

Employer _____ Address _____ Bus. Phone# _____ Ext _____

Who is responsible for this account? _____ Relationship to minor _____

Address _____ Home Phone _____ Bus. Phone # _____

Please give name, address and phone number of nearest relative NOT living with you _____

_____

How did you hear about us (Circle) Web Family Friend or other _____

How will this account be paid? (Check one) ☐ Cash/Check ☐Credit Card (Most major credit cards - no American Express) ☐Care Credit

EMPLOYEE SUBSCRIBER NAME FIRST MIDDLE LAST	RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD OTHER	SEX M F	PATIENT BIRTHDATE MO DAY YEAR	EMPLOYEE SOCIAL SECURITY NUMBER	EMPLOYEE BIRTHDATE MO DAY YEAR

EMPLOYER (COMPANY) NAME AND ADDRESS	DENTAL PLAN NAME	GROUP NO	DENTAL INS. PHONE

HEALTH HISTORY (Please circle yes or no or answer question):

Are you having any discomfort or pain from your mouth or face?..... Yes No

Are you under the care of a physician? ..... Yes No

For what reason? _____

Name and address of your physician? _____

_____

Have you ever been hospitalized? ..... Yes No

When? _____

For what? _____

Have you ever had surgery? ..... Yes No

For what? _____

Do you have any allergies to medications?..... Yes No

What? _____

Do you have any allergies? ..... Yes No

What? _____

Do you smoke more than 1/2 pack a day?..... Yes No

Do you chew tobacco? ..... Yes No

Are you pregnant now? .....What month? _____

Are you nursing?..... Yes No

Are you taking birth control pills? ..... Yes No

Are you taking medication to thin your blood?..... Yes No

Are you taking medications?..... Yes No

Please List Below_____

_____

Have you ever had any illness or complications associated with any previous dental treatment?..... Yes No

Are you currently taking Bisphosphonates (Bone densifying drugs/ Osteoporosis medication) ? ..... Yes No

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Anemia	Yes	No
Arthritis	Yes	No
Asthma	Yes	No
Bleeding Problems.....	Yes	No
Chest pain or Angina	Yes	No
Cold/Cough at present	Yes	No
Nasal obstruction at present	Yes	No
Contact Lenses	Yes	No
Diabetes	Yes	No
Epilepsy	Yes	No
Heart Disease, Heart Attack, Heart Murmur	Yes	No
Mitral Valve Prolapse	Yes	No
Hepatitis, Jaundice	Yes	No
High or Low blood pressure.....	Yes	No
Kidney or Bladder trouble	Yes	No
Liver Problems.....	Yes	No
Lung trouble, Emphysema, T.B., Pneumonia	Yes	No
Swollen ankles or legs.....	Yes	No
Rheumatic fever, Scarlet fever.....	Yes	No
Stroke.....	Yes	No
Cancer.....	Yes	No
Chemotherapy/Radiation	Yes	No
AIDS/ARC.....	Yes	No
Herpes/Venereal Disease	Yes	No
Have you ever been told you were HIV Positive?.....	Yes	No

(PLEASE READ AND SIGN REVERSE SIDE)