

**Personal Information**

Name: \_\_\_\_\_  
I prefer to be called: \_\_\_\_\_  
 Single    Married    Divorced    Widowed  
 Male    Female  
Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_   Age: \_\_\_\_\_  
SSN: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Street Address: \_\_\_\_\_  
Apt: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_  
Cell Phone: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_  
Email: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Work Phone: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_  
How did you hear about us? \_\_\_\_\_  
If referred, whom may we thank? \_\_\_\_\_

**Parent's Information**

**Mother**    Step Mother    Guardian  
Name: \_\_\_\_\_ Birthday: \_\_\_\_\_  
Home/Cell: \_\_\_\_\_ Work: \_\_\_\_\_  
Employer: \_\_\_\_\_  
SSN: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
**Father**    Step Father    Guardian  
Name: \_\_\_\_\_ Birthday: \_\_\_\_\_  
Home/Cell: \_\_\_\_\_ Work: \_\_\_\_\_  
Employer: \_\_\_\_\_  
SSN: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

**Dental Insurance**

**Primary Dental Insurance**

Insurance Co. Name: \_\_\_\_\_  
Insurance Co. Address: \_\_\_\_\_  
Insurance Co. Phone Number: \_\_\_\_\_  
Member ID: \_\_\_\_\_  
Group #: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_  
Insured's Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Insured's SSN: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Insured's Employer: \_\_\_\_\_  
Medical Insurance: \_\_\_\_\_

**Spouse Information**

Name: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Home/Cell: \_\_\_\_\_ Work: \_\_\_\_\_  
Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_   Age: \_\_\_\_\_

**Dental History**

Who was your previous Dentist? \_\_\_\_\_  
When was your last dental visit? \_\_\_\_\_  
When were you last dental xrays taken? \_\_\_\_\_  
Are you currently sensitive or in pain? \_\_\_\_\_  
Do you like your smile? \_\_\_\_\_  
How many times a day do you brush? \_\_\_\_\_  
How many times a week do you floss? \_\_\_\_\_

**I understand that I am responsible for payment of services rendered and also responsible for any copayment and deductibles that my insurance does not cover. If my bill is placed in the hands of an attorney or collection agency for purposes of collection after default, I promise to pay all reasonable attorney's fees and all other reasonable collection fees incurred. Furthermore, if a suit is instituted to enforce collection on my bill, I promise to pay all court costs associated with said legal action.**

**Our office policy is payment in full day of service. A 5% discount is offered for cash, check or credit card payments. We accept Mastercard and Visa. We also offer third party, no interest payment plans.**

**SIGNATURE**

**DATE**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

## Medical History

Although dental personnel primarily treat your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important relationship with the dentistry you will receive. Thank you for answering the following questions.

<b>Have you been informed to take a pre-medication before a dental appointment?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Are you under a physician's care now?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If yes, please explain:</i> _____		
<i>Physician's Name:</i> _____ <i>Phone #:</i> _____		
<b>Have you ever been hospitalized or had a major operation?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If yes, please explain:</i> _____		
<b>Have you ever had a serious head or neck injury?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If yes, please explain:</i> _____		
<b>Are you taking any medications, pills or drugs?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If yes, please list:</i> _____		
_____		
<b>Do you take, or have you taken Phen-Fen or Redux?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Have you ever taken any medications containing bisphosphonates?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Are you on a special diet?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Do you use tobacco?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Do you use controlled substances?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If yes, please list:</i> _____		
_____		

<b>Women Only:</b> Are you: <input type="checkbox"/> Pregnant/Trying to get pregnant?	<input type="checkbox"/> Nursing?	<input type="checkbox"/> Taking oral contraceptives?
<i>Due Date:</i> _____		

<b>Are you allergic to any of the following?</b> <input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Latex	<input type="checkbox"/> Metal
<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Tetracycline	<input type="checkbox"/> Local anesthetics	<input type="checkbox"/> Acrylics	<input type="checkbox"/> Others: _____

<b>Do you have, or have you had any of the following?</b>			
<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Radiation Treatments
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Recent Weight Loss
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Renal Dialysis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Easily Winded	<input type="checkbox"/> Herpes	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Angina	<input type="checkbox"/> Emphysema	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Hives or Rash	<input type="checkbox"/> Shingles
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fainting Spells/Dizziness	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Stomach/Intestinal Disease
<input type="checkbox"/> Breathing Problems	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Swelling of Limbs
<input type="checkbox"/> Cancer	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> Heart Pacemaker	<input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Yellow Jaundice			
<b>Have you ever had any serious illness not listed above?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<i>If yes, please explain:</i> _____			

<b>Comments:</b> _____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.	
<b>Signature of Patient, Parent or Guardian:</b> _____	<b>Date:</b> _____