PATIENT'S NAME _____ / _____ / _____
(first) (initial) (last)

Soc. Sec. #_____ - _____ - _____ **Birthdate**_____ **Sex**_____

RESPONSIBLE PARTY

Name_____ Soc Sec #_____ - _____ - _____ Birthdate_____
Address_____ City, State, Zip_____
Previous Address (if less than 3 years)_____
Home Phone_____ Work Phone_____ Ext_____ Cell _____
Occupation_____ Employer_____ Email _____
Spouse's Name_____ Soc Sec #_____ - _____ - _____ Birthdate _____
Spouse's Occupation_____ Employer_____ Wk. Phone _____
Name of nearest relative *not* living with you_____ Relationship _____
Address_____ City, State_____ Phone_____

INSURANCE INFORMATION

Primary Subscriber Name_____ Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other
Insured Soc. Security _____ - _____ - _____ Insured Birth Date_____
Employer_____ Ins. Company_____ Group # _____
Address_____ Address_____
City, State, Zip_____ City, State, Zip_____

Secondary Subscriber Name_____ Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other
Insured Soc. Security _____ - _____ - _____ Insured Birth Date_____
Employer_____ Ins. Company_____ Group # _____
Address_____ Address_____
City, State, Zip_____ City, State, Zip_____

CONSENT: I understand the above information is necessary to provide me with dental care in a safe and efficient manner. The information on this page is correct to the best of my knowledge.

RELEASE of benefits and information: I authorize my insurance benefits to be paid directly to the doctor. I am financially responsible for any balance due. I authorize the doctor or insurance company to release any information required for claims.

_____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

We keep a record of the health care services we provide you. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed. You are welcome to review this notice and receive a copy.

By my signature below I acknowledge receipt of the Notice of privacy Practices.

_____ _____
Patient or legally authorized individual signature Date Time

_____ _____
Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

I also give permission to the office to give information to ☐ my spouse, ☐ immediate family, or ☐ other _____

MEDICAL HISTORY

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

Are you under a physician's care now?	○ Yes ○ No	If yes _____
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes _____
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes _____
Are you taking any medications, pills or drugs?	○ Yes ○ No	If yes _____
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes _____
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you

Pregnant/Trying to get pregnant? ○ Yes ○ No Nursing? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

☐ Other If yes _____

Do you use controlled substances? ○ Yes ○ No If yes _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Depression	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatism	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Shingles	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Leukemia	○ Yes ○ No	Stroke	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Liver Disease	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Lung Disease	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Ulcers	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Venereal Disease	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pace Maker	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Yellow Jaundice	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Radiation Treatments	○ Yes ○ No		
Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No		

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes _____

Comments

_____

_____

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.

Signature of Patient, Parent or Guardian:

X _____ DATE _____

Reviewed by Dr. _____ Date _____

Reviewed by Dr. _____ Date _____

Reviewed by Dr. _____ Date _____