PATIENT INFORMATION

PATIENT

DR.
MR.
MRS.
MISS

PATIENT LAST NAME | FIRST NAME | MI. | DATE OF BIRTH

ADDRESS STREET | CITY | STATE | ZIP

PRIMARY PHONE # | PATIENT'S SOCIAL SECURITY # | SPOUSE'S NAME

EMAIL ADDRESS

EMERGENCY CONTACT | RELATIONSHIP | PHONE #

REFERRED BY | GENERAL DENTIST

INSURANCE

COMPLETE THIS SECTION IF YOU HAVE DENTAL INSURANCE

	Insurance Company Name	Policyholder (Subscriber) and DOB	Policy/Certificate Number and Subscriber Number
1.			
2.			

RESPONSIBLE PARTY

DR.
MR.
MRS.
MISS

LAST NAME | FIRST NAME | MI. | RELATIONSHIP TO PATIENT

ADDRESS STREET | CITY | STATE | ZIP

PRIMARY PHONE #

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. Payment is due at time of service. Any insurance benefits quoted are only an estimate of coverage. Any remaining balance will be the responsibility of the guarantor.

DATE | SIGNATURE OF PATIENT, PARENT, OR RESPONSIBLE PARTY

COMPLETE REVERSE SIDE

PATIENT HEALTH HISTORY

Patient Name: _____

Preferred Pharmacy/Address/Phone: _____

MEDICAL HISTORY

Your comfort and good dental health are dependent upon an accurate knowledge of your medical well being. Many medical situations can affect or be affected by procedures or drugs used for dentistry. Therefore, please fill out the following carefully. Thank You.

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Circle any of the following which you have had or do have now:

Heart trouble	Diabetes	Excessive bleeding	Lung/breathing trouble
Heart murmur	Arthritis	Epilepsy/seizures	Psychiatric treatment
Rheumatic fever	Tuberculosis	Positive to AIDS Virus	Radiation therapy
High blood pressure	Hepatitis	Sinus Disease	Prosthetic joint(s)
Asthma	Stroke	Glaucoma	Hiatal hernia
Fainting spell	Liver trouble	Venereal Disease	Alcohol/drug problem
Ulcers	Blood disorders	Kidney trouble	Jaw joint/TMJ issues
Sleep apnea/CPAP	Fibromyalgia		

Comments: _____

_____

Are you allergic to any food, drug or medication? Yes No

If yes, what? _____

Are you taking drugs or medication: Yes No

Medication:	Dosage (mg and # per day)	Action:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you pregnant? Yes No

If yes, number of months _____

Is there any other information about your health we should know? Yes No

_____

_____

Do you take herbal supplements? Yes No

If yes, what? _____

I understand that I am to return to my dentist for permanent restoration of the treated tooth.

Patient (Parent/Guardian) _____ _____

Signature Date

Complete Reverse Side