Patient Information **Date** .

Name_____Married___Single___Minor___Male___Female___
Last First MI

Address_____DOB____/____/____
Street City State Zip

Phone: Home( )_____Cell( )_____Work( )_____

E-mail address_____Preference for Appointment Confirmations: Email_____Phone text_____Both_____

Insurance/payment Information .

Dental Insurance Co._____Subscriber's place of Employment_____

Patient SS#_____Subscriber's(if not self) SS#_____and DOB_____/_____/_____

General Information: Self and Family .

If full time student,name of school_____Grade level_____

Has any member of your family been treated in our practice?Yes____No____Name_____

Whom may we thank for referring you to our practice?_____Your place of Employment_____

Husband(or father of Child patient)_____Wife(or mother of child patient)_____

Medical Health Information .

Physician's Name_____Date last seen_____

Any hospitalization in the past 5 years?Yes____No____ Reason_____

Have you had any serious illnesses or operations?Yes____No____ Explain_____

Are you taking any **medications**, pills or drugs?Yes____No____ **PLEASE LIST**:_____

Are you **allergic** to any medication or substance? Yes___No___Aspirin____Penicillin____Codeine____Novocaine____Latex____Other_____

Women: Are you Pregnant? Yes____No____ If yes, due date_____Are you nursing? Yes____No____

Do you smoke or use tobacco products?: Yes____No____ New patients: Date last seen in a dental office_____

Do you have or EVER had any of the following?(Please check)

Yes	No		Yes	No		Yes	No	
O	O	Heart Attack Date:_____	O	O	Excessive Bleeding	O	O	Diabetes
O	O	Shunts or stents placed Date:_____	O	O	Hepatitis-Type_____	O	O	Dialysis
O	O	Heart Valve Replacement	O	O	Exposure to AIDS virus	O	O	Asthma/other lung conditions
O	O	Any Congenital Heart Conditions	O	O	Tuberculosis	O	O	Psychiatric treatment
O	O	Pace maker Year_____	O	O	Auto-immune disease	O	O	Headaches/migraines
O	O	High Blood Pressure	O	O	Stroke or TIA	O	O	Malignancy
O	O	Congestive Heart Failure	O	O	Fainting or dizziness	O	O	Chemotherapy and/or radiation tx
O	O	Joint Replacement Year_____	O	O	Epilepsy or seizures	O	O	Dry Mouth

Do you have any other medical conditions or problems NOT listed on this form? If so, please explain:_____

_____

Have you had problems with prior dental treatment? If so, please explain:_____

_____

*The information on this page is correct to the best of my knowledge *I have received a copy of the Dental Materials Fact Sheet and HIPAA privacy policy
*I hereby authorize the dentist to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.
*I grant the right for the dentist to release my dental/medical and other information about my dental treatment to third party payors and/or other health professionals, as appropriate under the circumstances.
*I acknowledge full responsibility for the payment of fee for such services and agree to pay for them, in full, at the time of service, unless other arrangements have Been made in writing with a practice representative. As well as any fees not covered by insurance.
*If I have changes in my health or medications, I will inform the dentist and staff at my appointments.

X_____Date_____**OVER**