Today's Date__________

Patient Name __________ Date of Birth __________

Street__________ City __________ Zip __________

Home Phone ( )__________ Employer __________

Work Phone ( )__________ Occupation __________

Cell Phone ( )__________ Soc. Sec. # __________

Emergency Contact # __________

## INSURANCE INFORMATION

Dental Insurance__________ Subscriber __________ DOB __________

Subscriber's I.D.#__________ Employer __________

Group # __________ *If college student; name & address of college __________

*I the undersigned, give permission for treatment and I understand I am personally responsible for any amount that insurance does not cover; quotes from my insurance company is not a guarantee of benefits and my estimated co-payment is due at the time treatmen is completed. I understand if my insurance company does not pay the practice within a reasonable length of time (45 days) I will be billed for payment.*

Signature X__________

History of:

| | | |
|---|---|---|
| Tuberculosis | Yes | No |
| Cancer | Yes | No |
| Radiation | Yes | No |
| Heart Problems<br>*(coronary, angina, murmur heart or valve surgery)* | Yes | No |
| Pacemaker | Yes | No |
| Rheumatic Fever | Yes | No |
| High Blood Preasure | Yes | No |
| Low Blood Preasure | Yes | No |
| Bleeding Tendencies/Disorders | Yes | No |
| Anemia | Yes | No |
| Diabetes | Yes | No |
| Hepatisis - Type__________<br>*(if yes, late date tested negative)* __________ | Yes | No |
| Emphysema | Yes | No |
| Asthma/Reperatory Problems | Yes | No |
| Ulcers | Yes | No |
| Kidney Problems | Yes | No |
| Liver Problems | Yes | No |
| Thyroid Problems | Yes | No |
| Sinus Problems | Yes | No |
| Venereal Disease | Yes | No |
| HIV | Yes | No |
| AIDS | Yes | No |
| Glaucoma | Yes | No |
| Epilepsy or Seizures | Yes | No |
| Plate, Pins. Screws, or Artificial Joints | Yes | No |

Medical History:

| | | |
|---|---|---|
| Do you smoke/chew tobacco? | Yes | No |
| Have you had any recent surgery? | Yes | No |
| Are you taking steroids? | Yes | No |
| Are you allergic to any of the following: | | |
| Penicillin | Yes | No |
| Aspirin | Yes | No |
| Codeine | Yes | No |
| Local Anesthesia *(novacaine)* | Yes | No |
| Other Medications | Yes | No |
| Latex | Yes | No |
| Other Allergies | Yes | No |

__________

__________

Do you have any medical problems not listed above?

__________

__________

Please list any medications you are taking *(including birth control or aspirin)* __________

__________

Your Physicians name, address, & phone number:

__________

__________

Women: Are you pregnant? Yes No

Who should we thank for referring you to us? __________