PLEASE PRINT

Name:____ Date of Birth: _________/______/____________

Address: ____ Email:____________________________________

City:____ State:_____________ Zip: ___________________________

Home Phone: ____________________________ Work Phone: __________________________ Cell:________________________

Social Security: _____________________________ Employer:____

Emergency Contact:__________________________________ Phone: ____________________ Relation: ____________________

Method of Payment for Today's Visit (circle) Cash Check Credit Card: Visa MC Disc Amex

Do you have Dental Insurance? (yes) (No) If (yes) Carrier: _____________________ Policy/Group #_______________________

How did you hear about us? (circle) .... Phone Book .... Referal .... Sign .... Newspaper .... Mail .... Radio/Tv .... Insurance Company ....

If referral, whom may we thank? ____

Please explain reason for your visit today: ____

Are you allergic to any medications? (yes) (no) If yes, please list below: ____

____

Are you presently taking any medications? (yes) (no) If yes, please list below:____________________________________

____

Do you have, or have you ever had any of the following? Circle yes no.

Condition			Condition		
Heart Murmur	yes	no	Artificial Joints	yes	no
Venereal Disease	yes	no	Tuberculosis or Respiratory Problems		
Rheumatic Fever	yes	no	Heart Problems	yes	no
Aids / HIV	yes	no	Pacemaker	yes	no
History of Bleeding	yes	no	Kidney Disease	yes	no
Diabetes	yes	no	Hepatitis, Jaundice or other Liver Problems	yes	no
High Blood Pressure	yes	no	Women:		
Anemia	yes	no	Are you pregnant?	yes	no
Reaction to Anesthetic	yes	no	Taking oral contraception?	yes	no
Epilepsy / Seizures	yes	no			
Herpes	yes	no			
Thyroid Problems	yes	no			

Are you taking an Anticoagulant? (E.g. Coumadin) yes no If yes, please list. ____________________________________

Do you take High Blood Pressure medication? yes no If yes, please list. ____

Are you under a physician's care now? yes no Nature of treatment? ____

Physicians Name ____ Phone Number ____

Payment is due when services are rendered. All x-rays and digital images are property of Classic Dental, Inc. Duplicates are available at a cost of $20.00. I understand that I am responsible for all fees incurred on my behalf regardless of my insurance status. I understand that I am responsible for all costs incurred by Classic Dental, Inc. If collection action becomes necessary for accounts over 30 days past due. I have read the above information and certify that my responses are true and accurate.

Patient's Signature:____ Date: ___________________________________