

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 Referral 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.

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