PLEASE FILL IN ALL INFORMATION – PLEASE PRINT

Today's Date ________________________________

Name_____________________________________S.S. Number__________________Birth Date______/_______/______

Address____City_______________State_______Zip Code____________

Home Phone Number(____)_________________________________Cell No.(____)______________________________

Preferred method of appointment confirmation: Home number___Cell number___

Email [not for marketing purposes]_______________________________________Single_Married_Widowed_Divorced_

Employed by____Work Phone Number(____)____________________

Occupation_________________________________Name of Spouse / Parent_____________________________________

Employed by____Occupation______________________________________

Employer's Address_______________________________________Work Phone Number(____)____________________

Physician____Phone Number(____)________________________

Name and phone number of emergency contact not at above address__________________________(____)___________

Name of person financially responsible for this account____

Do you have Dental Insurance?________**If yes, please answer questions on reverse side ------------>>>>**

MEDICAL / DENTAL HISTORY

	YES	***NO***
Are you in good general health at this time?	____	____
Are you pregnant?	____	____
Are you under any medical treatment now?	____	____

Please list any major operations_____________________ ____

Have you had any prosthetic operations, such as hip, knee or joint replacement?	____	____
Have you had any head injuries?	____	____
Are you allergic to latex, latex products or rubber products?	____	____
Have you had any adverse response or allergic reactions to any drugs?	____	____

If yes, please list drugs____

Has a physician ever informed you that you have had: (Circle all that apply)

Heart ailment/Angina	Mitral valve prolapse	Low or High blood pressure	Sinus problems
Respiratory Disease	Diabetes	Rheumatic fever	Rheumatism
Blood disease	Liver disease	Kidney disease	Hepatitis
Stroke	Thyroid disease	Arthritis	Anesthesia problem

Do you have any infectious diseases?	____	____
Are you taking any drugs, medications, or herbals?	____	____

If yes, please list them____

Do you smoke or use smokeless tobacco?	____	____
Do you consume more than 2 ounces of alcohol a day?	____	____
Do you have a history of fainting?	____	____
Do you have any pain in or near your ears?	____	____
Have you experienced any growths or sore spots in your mouth?	____	____
Do your wounds heal slowly?		
Have you <u>ever</u> taken bisphosphonate drugs? (Bone density drugs) (Examples: Fosamax, Boniva, Reclast)	____	____
Have you had any reactions or allergic reactions to dental anesthetic (Novocain)?	____	____
Have you had any particularly difficult extractions or dental work?	____	____
Have you had any prolonged bleeding following dental work?	____	____
Do your gums bleed?	____	____
Have you had instructions on the correct method of flossing and brushing?	____	____

When was your last dental visit?____

SIGNATURE____

PRIMARY CARRIER INSURANCE

Employee's name__________________________________S. S. Number__________________Birth date____/____/____

Employer name__________________________________Occupation____

Group number____________________________________Member ID number___________________________________

Insurance carrier name____Insurance phone __________________________

Insurance carrier address____

City____State_________________________Zip code______________

Who is covered under this plan? Self______Spouse____Dependents____

SECONDARY CARRIER INSURANCE (IF APPLICABLE)

Employee's name__________________________________S. S. Number__________________Birth date____/____/____

Employer name____

Group number____________________________________Member ID number___________________________________

Insurance carrier name____Insurance phone __________________________

Insurance carrier address____

City____State_________________________Zip code______________

Who is covered under this plan? Self______Spouse____Dependents____

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FINANCIAL RESPONSIBILITY

I agree that I am financially responsible for charges not covered by insurance.

Name of responsible party____

Signature____

Date____