Please answer the following questions as accurately as possible. This information is necessary in providing our best service to you, and of course, is confidential.

Date _____

Patient's Name _____ Age _____

Home Address _____ Sex _____

City _____ State _____ Zip _____

Telephone: Home _____ Marital Status _____ Birthdate _____

Cell _____ Work _____ Email Address _____

Employed By: _____ Social Security No. _____

Insured's Name: _____ Insured's Employer: _____

Insured's Social Security No. _____ Insured's Birthdate _____

Your Physician's Name: _____ Phone _____

Your Dentist's Name: _____ Phone _____

Whom shall we thank for recommending us to you? _____

Have you, or other family members been our patient before? _____

Dental Insurance Name _____

Subscriber No. _____

Plan _____

1. Are you under the care of a physician at present? _____
   What for? _____ Last seen? _____
2. Are you allergic to any drugs or medicine? _____
   What? _____
3. Are you taking any medicine at present? _____
   What? _____
4. Are you in good health? _____
5. Have you had any of the following?

	Yes	No
HIV Status (Aids)		
Asthma or Lung Disease		
Heart Murmur		
High Blood Pressure		
Rheumatic Fever		
Kidney disease		
Diabetes		
Anemia or blood disease		
Prolonged bleeding		
Liver disease or hepatitis		
Chest pains		
Fainting spells		
Venereal disease		
Epilepsy		
Major operation		
Radiation treatments		
Glaucoma		
Ulcers		
Hives or skin rash		
Stroke		
Cardiovascular disease (Heart attack)		
Arteriosclerosis		
Cancer		

6. Do you have a cold or the flu now? _____
7. Are you pregnant? _____
8. Have you taken steroids? (ACTH, CORTISONE) _____
9. **Do you have any health problems not listed above?** _____
10. In the event that this account is assigned to an agency or attorney for collection and/or suit, the responsible party will incur all costs of collection including reasonable attorney fees (33 1/3%).

Signature _____