PATIENT INFORMATION

Name: ____________________ Sex: M ☐ F ☐

Status: Single ☐ Married ☐ Minor ☐ College Student ☐ (school:____________________)

Address: ____________________ Age:_______ DOB:_____________ SSN:__________________

City: ____________________ State: _________ Zip:___________

Primary Phone:____________________ Alternate Phone:____________________

Email:____________________

Whom may we thank for your referral?

____

INSURANCE INFORMATION

Name of Insured: ____________________ Relationship to Insured: ______________

Occupation: ____________________ Birthdate: ____________________ SSN:____________________

Name of Employer: ____________________ Group #: ____________________

Insurance Company: ____________________ Subscriber ID: ____________________

Insurance Company Address: ____________________ State: _________ Zip:________________

MEDICAL HEALTH INFORMATION

Please check any that apply:

- ☐ AIDS
- ☐ Anemia
- ☐ Arrhythmia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bleeding Condition
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Fainting
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Hay Fever/ Allergies
- ☐ Head Injury
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis/ Jaundice
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ HIV
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Osteoporosis/Osteopenia
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Stomach Troubles/Ulcers
- ☐ Stroke
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ Venereal Disease

OTHER:

____

Family Physician:____________________

Are you allergic to any of the following?

- Latex
- Penicillin
- Codeine
- Sulfa
- Erythromycin
- Clindamycin
- Amoxicillin
- Cipro
- Aspirin
- Other

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List Medications/Supplements:

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DENTAL INFORMATION

Do any of the following apply to you:

- ☐ Bleeding gums
- ☐ Grind teeth
- ☐ Loose teeth
- ☐ Bad breathe
- ☐ Bad taste
- ☐ Chipped tooth
- ☐ Snoring
- ☐ Sensitive to hot
- ☐ Sensitive to cold
- ☐ Biting pain
- ☐ Periodontal treatment
- ☐ Recent mouth trauma
- ☐ Other:____________________
- ☐ Sleep apnea device

My last dental visit roughly:_______________

Last Dentist:____________________ Reason for leaving:______________

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient or Parent/Guardian Signature____________________ Date:____________________