

PATIENT INFORMATION AND HISTORY
(Confidential information for our records)

(Please print clearly) SOC.SEC# _____
NAME _____ AGE _____ BIRTHDATE _____
(Last name) (First) (M.I.)
HOME ADDRESS _____ CITY _____ ZIP _____
HOME PHONE _____ WORK PHONE _____ CELL PHONE _____
EMPLOYED BY _____ OCCUPATION _____
SPOUSE'S NAME _____
REFERRED BY _____ RELATIONSHIP TO YOU _____
NAME OF PERSON FINANCIALLY RESPONSIBLE _____ RELATIONSHIP _____

DENTAL INSURANCE INFORMATION

NAME OF PRIMARY DENTAL INSURANCE _____ GROUP# _____
NAME OF PRIMARY INSURED _____ RELATIONSHIP TO PATIENT _____
ADDRESS (if different than above) _____ PHONE # (if different) _____
PRIMARY INSURED SOC. SEC# _____ BIRTHDATE _____
EMPLOYED BY _____
EMPLOYER'S ADDRESS _____ ZIP _____
EMPLOYER'S PHONE# _____

NAME OF SECONDARY DENTAL INSURANCE _____ GROUP# _____
NAME OF SECONDARY INSURED _____ RELATIONSHIP TO PATIENT _____
ADDRESS (if different than above) _____ PHONE # (if different) _____
SECONDARY INSURED SOC. SEC# _____ BIRTHDATE _____
EMPLOYED BY _____
EMPLOYER'S ADDRESS _____ ZIP _____
EMPLOYER'S PHONE# _____

DENTAL/MEDICAL HISTORY

When was your last visit to a dentist? _____ Name of dentist you were treated by? _____ Have you had a full mouth X-ray? _____ Have you been told by a doctor that you have to take an anti-biotic before dental cleanings/procedures? _____ Do you have any of the following conditions? (please circle) High Blood Pressure—Heart Trouble—Diabetes—Asthma—Anemia Tuberculosis—Kidney or Liver involvement—Blood Disease—AIDS Arthritis—Ear Trouble—Rheumatic Fever—Epilepsy—Hepatitis (Please indicate yes or no) Are you sensitive or allergic to any medications or anesthetics? _____ Are you subject to profuse bleeding? _____ (Women) Are you pregnant? _____ Are you under the care of a Physician? _____ If Yes, for what purpose? _____	Are you taking any medication now? _____ If yes, please list them and tell us why you are taking them. _____ _____ _____ Have you had any major surgery within the last 5 years? _____ If yes, please explain _____ _____ Have you ever had radiation treatment to the neck/head? _____ Who is your Medical Physician? _____ Phone # _____ REMARKS _____ _____ _____
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Please give us at least 48 hours notice if unable to keep your appointment. Failure to keep appointments, or failure to notify this office of cancellations, within a 24-hour period of appointment, will result in a \$25.00 charge.

I understand that I am responsible for the charges incurred. In the event that I fail to pay these charges, I will be responsible for 25% collection costs associated with the cost of resolving my account.

Signature X _____ Date _____