

PATIENT DATA FOR TREATMENT - PLEASE COMPLETE FORM IN ITS ENTIRETY (TWO SIDES)

LEGAL NAME FIRST MIDDLE LAST
 MR. MRS. MS. DR. _____

ADDRESS: _____ CITY/STATE/ZIP _____

HOME# () CELL# () D.O.B SS#

AGE: _____ MALE: _____ FEMALE: _____ LANGUAGE: _____ EMAIL ADDRESS: _____

EMPLOYER NAME: _____ PHONE# () OCCUPATION _____

EMPLOYER ADDRESS: _____ CITY: _____ STATE/ZIP: _____

DRIVERS LICENSE/STATE ID#: _____ STATE ISSUED: _____ EXPIRATION DATE: _____

MARITAL STATUS (Circle One): SINGLE MARRIED DIVORCED WIDOWED

SPOUSE NAME: _____ DOB: _____ SS#: _____

REFERRED TO US BY: _____ REASON FOR VISIT: _____

DATE OF LAST PHYSICAL EXAM: _____ / _____ / _____

In the following questions, circle "Y" for yes or "N" for no. Your answers are for our records only and will be kept confidential.

DO YOU USE ANY OF THE FOLLOWING?	Cigarettes Y or N	Snuff Y or N	Chewing Tobacco Y or N
HAVE YOU EVER HAD:	HAVE YOU EVER TAKEN ANY OF THESE MEDICATIONS:		
Y or N MITRAL VALVE PROLAPSE	Y or N FEN PHEN OR REDUX		
Y or N HEART MURMUR	Y or N AREDIA/ZOMETA/FOSAMAX/ACTONEL/BONIVA		
Y or N RHEUMATIC FEVER (HISTORY OF)	HAVE YOU EVER HAD ANY INFECTIOUS DISEASES:		
Y or N ABNORMAL HEART CONDITIONS (HEART SURGERY, HEART ATTACK, HEART INFECTION (ENDOCARDITIS), STENT, CONGENITAL DEFECTS, ANGINA, ETC.)	Y or N HEPATITIS/TUBERCULOSIS		
Y or N CONGESTIVE HEART DISEASE	Y or N VENEREAL DISEASES/GONORRHEA/ SYPHILIS/HERPES		
Y or N ARTIFICIAL HEART VALVE or DEFECTIVE HEART VALVE	Y or N AIDS/HIV POSITIVE/ARC		
Y or N PACEMAKER	ARE YOU:		
Y or N PROSTHETIC DEVICES	Y or N PREGNANT? If Yes, for how long? _____		
Y or N JOINT REPLACEMENTS (KNEE, HIP, ETC.)	Y or N TAKING BIRTH CONTROL PILLS? *		
Y or N ABNORMAL BLEEDING (PAST/PRESENT)	Y or N ALLERGIC TO A LOCAL ANESTHETIC?		
Y or N HIGH BLOOD PRESSURE	Y or N ALLERGIC TO LATEX?		
Y or N ANEMIA	Y or N ALLERGIC TO ANY MEDICATIONS/FOOD? IF YES, WHAT? _____		
Y or N LIVER/KIDNEY PROBLEM/CIRRHOISIS, ETC.	Y or N TAKING ANY BLOOD THINNERS IF YES, WHAT? _____		
Y or N SICKLE CELL ANEMIA/TRAIT	Y or N ANY OTHER PAST OR CURRENT MEDICAL CONDITIONS? IF YES, WHAT? _____		
Y or N DIABETES/ENDOCRINE DISORDERS.			
Y or N ASTHMA/EMPHYSEMA/RESPIRATORY PROBLEMS			
Y or N SINUS/NASAL PROBLEMS			
Y or N CHEMO THERAPY TREATMENT FOR CANCER			
Y or N TREATMENT FOR OSTEOPOROSIS			
Y or N RADIATION THERAPY			

PHYSICIAN'S NAME: _____ PHONE # () _____

List all prescription, herbal, over the counter medications, or birth control pills you are currently taking:

*Antibiotics are often prescribed in the course of dental treatment. They can interfere with the absorption of birth control pills, thus making them ineffective. While taking antibiotics, alternative methods of contraception are recommended.

PATIENT/FINANCIAL RESPONSIBLE PARTY SIGNATURE: _____ DATE _____

PATIENT'S SIGNATURE (If different from Financially Responsible Party and over 18 years old): _____ DATE _____

PATIENT DATA FOR TREATMENT - PLEASE COMPLETE FORM IN ITS ENTIRETY (TWO SIDES)*****PRIMARY DENTAL INSURANCE*****

PRIMARY DENTAL INSURANCE PLAN NAME _____ PHONE # () _____

ADDRESS _____ CITY/STATE/ZIP _____

POLICY/ID # _____ GROUP# _____ EFFECTIVE DATE _____

SUBSCRIBER INFORMATION: RELATIONSHIP TO PATIENT _____ (IF SELF, SKIP TO NEXT SECTION)

NAME _____ SS # _____ D.O.B _____

ADDRESS _____ CITY/STATE/ZIP _____

HOME# _____ CELL#() _____ WORK PHONE # () _____

EMPLOYER NAME/ADDRESS _____ OCCUPATION _____

UNION NAME & PHONE # (If Applicable) _____

****SECONDARY DENTAL INSURANCE****

SECONDARY DENTAL INSURANCE PLAN NAME _____ PHONE # () _____

ADDRESS _____ CITY/STATE/ZIP _____

POLICY/ID # _____ GROUP# _____ EFFECTIVE DATE _____

SUBSCRIBER INFORMATION: RELATIONSHIP TO PATIENT _____ (IF SELF, SKIP TO NEXT SECTION)

NAME _____ SS # _____ D.O.B _____

ADDRESS _____ CITY/STATE/ZIP _____

HOME# _____ CELL#() _____ WORK PHONE # () _____

EMPLOYER NAME/ADDRESS _____ OCCUPATION _____

UNION NAME & PHONE # (If Applicable) _____

****RESPONSIBLE PARTY INFORMATION******IF PATIENT IS A MINOR, THIS SECTION MUST BE COMPLETED**

NAME OF RESPONSIBLE PARTY _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ CITY/STATE/ZIP _____ D.O.B _____

SS# _____ HOME # () _____ CELL # () _____

EMPLOYER NAME & ADDRESS _____ CITY/STATE/ZIP _____

EMPLOYER PHONE _____ OCCUPATION _____

****EMERGENCY CONTACT INFORMATION****

NAME OF EMERGENCY CONTACT _____ RELATIONSHIP _____

HOME PHONE# () _____ WORK PHONE# () _____ EXT _____

ADDRESS _____ CITY/STATE/ZIP _____ PHONE () _____

CLOSEST RELATIVE NOT LIVING WITH YOU _____ RELATIONSHIP _____

ADDRESS _____ CITY/STATE/ZIP _____ PHONE () _____

IS ANOTHER MEMBER OF YOUR FAMILY A PATIENT OF OURS? YES _____ NO _____

IF YES, WHO? _____ RELATIONSHIP _____