Patient Information

Married _____ Single _____
Divorced _____ Widowed _____

NAME _____ Nickname _____
LAST FIRST M

ADDRESS _____ ☐ OWN ☐ RENT
STREET APT.# CITY STATE ZIP

Landlord's Name, Address, and Phone: _____

If less than 2 years, previous address: _____

SOCIAL SECURITY NUMBER _____

BIRTH DATE _____ TELEPHONE _____ _____
HOME WORK

PLACE OF EMPLOYMENT _____ _____
ADDRESS

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

DENTAL INSURANCE CO. _____ GROUP # _____

ADDRESS _____

PHONE # _____

Is any member of your family currently a patient at this office? ☐ Yes ☐ No

How did you hear about us? ☐ Person_____ ☐ Internet ☐ Insurance
☐ Talking Phone Book ☐ Yellow Pages

Family Information

FATHER (or husband)	MOTHER (or wife)
LAST FIRST M	LAST FIRST M
STREET CITY STATE ZIP	STREET CITY STATE ZIP
HOME TELEPHONE# WORK TELEPHONE#	HOME TELEPHONE# WORK TELEPHONE#
BIRTH DATE (MO/D/YR) SS#	BIRTH DATE (MO/D/YR) SS#
EMPLOYER ADDRESS	EMPLOYER ADDRESS
DENTAL INSURANCE CO. GROUP #	DENTAL INSURANCE CO. GROUP #

Method of Payment

Person responsible for account: (please check one)
- ☐ Patient
- ☐ Guardian
- ☐ Father (or husband)
- ☐ Mother (or wife)

Responsible party currently has an account in this office?
☐ YES ☐ NO

- ☐ Payment in full at each appointment
- ☐ VISA ☐ MasterCard
- ☐ Discover ☐ Care Credit
- ☐ Am. Exp.

Medical History

	Y	N
Are you under a physician's care at this time?	☐	☐
Have you ever been hospitalized or had a major operation?	☐	☐
Have you ever had an injury to your head or neck?	☐	☐
Are you on a special diet?	☐	☐
Do you smoke?	☐	☐
Would you like to quit smoking?	☐	☐
Are you currently taking any medications, drugs, or pills?	☐	☐

Please list below.

_____

Are you allergic to anything?	☐	☐

Please list. _____

Have you ever taken bisphosphonates? (Fosamax, Actonel, or Boniva)?	☐	☐

Who is your physician? _____

	Y	N
Heart Trouble/Disease	☐	☐
Mitral Valve Prolapse	☐	☐
Artificial Heart Valve	☐	☐
Heart Murmur	☐	☐
Chest Pain	☐	☐
Heart Attack (Date)_____	☐	☐
Congestive Heart Disease	☐	☐
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Rheumatic Fever	☐	☐
Scarlet Fever	☐	☐
Excessive Bleeding	☐	☐
Shortness of Breath	☐	☐
Lung Disease	☐	☐
Frequent Cough	☐	☐

	Y	N
Osteoporosis	☐	☐
Hay Fever	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
TB	☐	☐
Cancer	☐	☐
Radiation Treatment	☐	☐
Chemotherapy	☐	☐
Digestive Tract Disease	☐	☐
Ulcers	☐	☐
Recent weight loss	☐	☐
Diabetes	☐	☐
Hypoglycemia	☐	☐
Liver Disease	☐	☐
Hepatitis A (infectious)	☐	☐
Hep. B (serum) /Carrier?	☐	☐

	Y	N
Kidney Trouble	☐	☐
Renal Dialysis	☐	☐
Thyroid Disease	☐	☐
Parathyroid Disease	☐	☐
Arthritis/Gout	☐	☐
Artificial Joints	☐	☐
AIDS or HIV Positive	☐	☐
Herpes	☐	☐
Seizures	☐	☐
Stroke	☐	☐
Are you scared?	☐	☐
Fainting or Dizzy	☐	☐
Alzheimer's	☐	☐
Pregnant (trimester___)	☐	☐
Psychological Evaluation	☐	☐
Other _____	☐	☐

Medical Updates

Office Use Only

Date	BP	Reviewed by:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Authorization

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. **I understand that I am responsible for all costs of dental treatment.** In the case of default, I promise to pay the balance, any legal interest, and cost of collections which include a reasonable attorney's fee on my account. A late cancellation/no show fee of $50.00 can be added to my account if frequent broken appointments make it necessary.

To the best of my knowledge, all of the above answers are correct. If there are any changes in my medical health, I will inform the dentist before my next appointment or before any treatment is started. I have read and agree to all the terms of this form. (Person signing form must be at least 18 years old)

X _____ **Date** _____