PATIENTS INFORMATION

Last Name____________________________ First Name_________________________ M.I._______

Date of Birth ____________________ Social Security # _____________________ Sex: M___ F___

Marital Status: Single ____ Married ____ Divorced ____ Widowed ____ Separated ____ Other ____

Address ____ Apt. # ____________

City ________________________________ State ____________________ Zip Code _____________

Home Phone ___________________________ Work Phone __________________________________

Cell Phone ________________________ E-mail ____

Driver License # ________________________State ________________ Exp. Date _____________

Employer ___________________________ Occupation ______________________________________

Name of Spouse ____________________________ Occupation ________________________________

Referred By ____

Name of Parents (if under age) ____

Name of School (for Dependent children) ______________________________ City _______________

In Case of Emergency Please Call: _____________________________Tel. # ______________________

FOR WOMEN ONLY

Are you pregnant or think you may be pregnant? Y/N If YES, due date __________________________

Are you nursing? Y/N Are you taking birth control medication Y/N

List of **MEDICATIONS** taken daily: ____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING: Circle 'Y' for yes or 'N' for no

Physician Name and Tel. #: ____

Y/N Local Anesthetics
Y/N Codeine
Y/N Penicillin/ Antibiotics
Y/N Sedatives
Y/N Sulfra Drugs
Y/N Lodine
Y/N Any Metals
Y/N Latex
Y/N Aspirin
Other: ___________________________________

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING: Circle 'Y' for yes or 'N' for no

Y/ N High/ Low Blood Pressure
Y/N Heart Disease
Y/N Hepatitis Type ______
Y/N Heart Attack
Y/N Stroke
Y/N Ulcers
Y/N Rheumatic Fever
Y/N Cardiac Pacemaker
Y/N Joint Replacement or Implant
Y/N Fainting/ Seizures
Y/N Angina Pectoris
Y/N Hay Fever/ Allergies
Y/N Asthma
Y/N Heart Murmur
Y/N Tuberculosis
Y/N Leukemia
Y/N Anemia
Y/N Glaucoma
Y/N Diabetes
Y/N Emphysema
Y/N Radiation Therapy
Y/N Kidney Disease
Y/N Cancer
Y/N Mitral Valve Prolapse
Y/N Thyroid Problem
Y/N Liver Disease
Y/N Heart Surgery
Y/N AIDS or HIV
Y/N Arthritis
Y/N Drug Addiction
Y/N Sinus Trouble
Y/N Psychiatric treatment
Y/N Sexual Transmitted Disease
Y/N Cholesterol
Others not listed:____

AUTHORIZATION

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I authorize the insurance company indicated on my file to pay the dentist insurance benefits otherwise payable to me for services rendered I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all changes whether or not paid by insurance.

SIGNATURE ____________________________________ **DATE** _________________________

Payment is due in full at the time of treatment unless prior arrangements have been approved