PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____ Date of Birth / /

Address _____ Town _____

State _____ Zip _____ Telephone # _____

Recommended By _____ Name of Physician _____

Social Security # _____ Marital Status _____

Full-Time College Student ____ Yes ____ No College _____

Place of Employment _____ Business Telephone # _____

Business Address _____

Person Responsible for Account _____ Tel. # _____

DENTAL INSURANCE INFORMATION

Last Name _____ First Name _____ Relationship to Patient _____

Address _____

Town _____ State _____ Zip _____

Res. Telephone # _____ Date of Birth _____ Social Security # _____

Place of Employment _____ Bus. Telephone # _____

Business Address _____

Dental Insurance Carrier Insurance Address _____ Group Policy # _____

Insurance Address _____

PATIENT HISTORY

Are you under a physicians care now? O Yes O No O N/A _____

Have you ever been hospitalized or had a major operation? O Yes O No O N/A _____

Have you ever had a serious head or neck injury? O Yes O No O N/A _____

Are you taking any medications, pills, or drugs? O Yes O No O N/A _____

Do you take, or have you taken, Phen-Fen or Redux? O Yes O No O N/A Do you use Tobacco? O Yes O No O N/A

Are you on a special diet? O Yes O No O N/A Do you use controlled substances? O Yes O No O N/A

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other _____

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disease	☐ Glaucoma	☐ Leukemia	☐ Sicle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur*	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve*	☐ Drug Addiction	☐ Heart Pace Maker*	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Artificial Joint*	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsilitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruises Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever*	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? O Yes O No O N/A _____

Date _____ Patient/Parent's Signature _____