Name: _____ Today's Date: _____

Address: _____ Zip: _____

S.S.# _____ Sex: _____ Date of Birth: _____

Home Telephone: _____ E-mail Address: _____

Work Telephone: _____ Occupation: _____

Cellular Telephone: _____ Emergency Contact _____

Name of Spouse: _____ Emergency Contact phone # _____

Whom may we thank for referring you to our office? _____

Who is your general dentist? (Name, address, phone #) _____

Who is your physician? (Name, address, phone #) _____

Responsible Party: _____

Primary insurance company: _____ Secondary company: _____

Address _____ Address _____

Policy # _____ Group # _____ Policy # _____ Group # _____

Issued in the name of: _____ Issued in the name of: _____

Date of Birth: _____ SS# _____ Date of Birth: _____ SS# _____

Employed by: _____ Employed by: _____

Have you ever been told that you have rheumatic heart disease, rhematic fever or a heart murmur? ..... YES ..... NO

Do you have a prosthetic heart valve or prosthetic joint replacement? ..... YES ..... NO

Do you require antibiotic premedication prior to dental treatment? ..... YES ..... NO

Have you ever been in the hospital? ..... YES ..... NO Please list and describe: _____

Are you currently taking any medications? ..... YES ..... NO Please list and describe: _____

Are you allergic to any medications? ..... YES ..... NO Please list and describe: _____

Do you take aspirin regularly? ..... YES ..... NO Do you take medication for osteoporosis? ..... YES ..... NO

Do you take coumadin or other blood thinner regularly? ..... YES ..... NO Drug Name: _____

Have you ever reacted to penicillin, aspirin, codeine, novocaine or other anesthetic? ..... YES ..... NO

Please list and describe: _____

CONTINUED ON THE BACK OF THIS PAGE

Have you ever had: (please circle yes or no)

Mitral valve prolapse	YES	NO	Asthma	YES	NO
Heart failure	YES	NO	Diabetes	YES	NO
Heart disease	YES	NO	Cancer	YES	NO
Angina	YES	NO	Thyroid problems	YES	NO
Hypertension(high blood pressure)	YES	NO	Blood transfusion	YES	NO
What pressure do you usually run? ____/____			Drug addiction	YES	NO
Stroke	YES	NO	Hemophilia	YES	NO
Tuberculosis	YES	NO	Excessive bleeding	YES	NO
Kidney trouble	YES	NO	Venereal Disease	YES	NO
Ulcers	YES	NO	Cold Sores	YES	NO
AIDS	YES	NO	Epilepsy or seizures	YES	NO
Hepatitis	YES	NO	Fainting or dizziness	YES	NO
Liver disease	YES	NO	Psychiatric treatment	YES	NO
Are you pregnant	YES	NO	Are you under a Dr's care	YES	NO

When did you last have your teeth professionally cleaned? _____

When did you last have x-rays taken of your teeth? _____

_____ _____

Patient signature date

_____ _____

date

Pharmacy Name _____ Pharmacy Phone# _____

I authorize the dentist to release any information including the diagnosis & record of any treatment or examination rendered to me during the period of such dental care to 3rd party payors &/or health practitioners. I authorize and herby request my insurance company to pay directly to the dentist,insurance benfits otherwise payable to me. I understand that the insurance carrier may pay less than the actual bill for services. I agree to be responsible for all services rendered on my behalf. LATE CHARGES: If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). In the case of default on payment of this account, I aggree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.