

Patient Information

Date _____

Patient's Name _____ Male Female
Last First Middle

Address _____ Phone _____
Street City State Zip

Birthdate _____ Social Security # _____ 18yrs/older – School Attending _____

If patient is a minor give parent or guardian name _____

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

Responsible Party Information

Name _____ Single Married Divorced Separated
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____ Email _____

Previous Address (if less than 3 yrs.) _____

Social Security # _____ Birthdate _____

Relationship to Patient: Mother Father Stepmother Stepfather Legal Guardian Other _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____
Last First Middle

Relationship to Patient: Mother Father Stepmother Stepfather Legal Guardian Other _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Dental Insurance Information

Insured's Name _____ Birthdate _____ Insured's Social Security # _____

Insured's Address _____ Phone _____
Street City State Zip

Relationship to Patient: Mother Father Stepmother Stepfather Legal Guardian Other _____

Insurance Carrier _____ Group No. _____ Local No. _____

Insurance Carrier Address _____

Insured's Employer _____

Do you have dual coverage? Yes No If yes:

Insured's Name _____ Birthdate _____ Insured's Social Security # _____

Insured's Address _____ Phone _____
Street City State Zip

Relationship to Patient: Mother Father Stepmother Stepfather Legal Guardian Other _____

Insurance Carrier _____ Group No. _____ Local No. _____

Insurance Carrier Address _____

Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____ Relationship _____

Complete Address _____ Phone _____
Street City State Zip

I understand that where appropriate, credit bureau reports may be obtained

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

Name of Patient's Medical Doctor _____

Is patient allergic to (ie: itching, rash, swelling of hands, feet, or eyes) or made sick by penicillin, aspirin, codeine, latex, any drugs or medication? _____

Does patient have any food allergies? _____

Please check any of the following which patient has, or has had.

- | | | |
|--|---|---|
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Heart Disease or Attack |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis A (infectious) |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> Hepatitis B (serum) |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> X-Ray or Cobalt Treatment |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Chemotherapy (Cancer, Leukemia) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Venereal Disease (Syphilis, Gonorrhea) |
| <input type="checkbox"/> HIV, AIDS, or ARC | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fainting or Dizzy Spells |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Artificial Heart Valve |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Congenital Heart Lesions |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Cortisone Medicine |
| <input type="checkbox"/> Yellow Jaundice | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Pain in Jaw Joints |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Blood Transfusion |

Has patient had any other disease or medical condition not listed? Yes No What _____

Is patient in the care of a Physician now? Yes No What for? _____

Is patient taking any medications? Yes No What? _____

Is patient allergic to anything? Yes No What? _____

Women only — Is patient pregnant? Yes No Months? _____

Has patient ever used phen-fen? Yes No When/How long? _____

Does patient have clicking or popping noises when they chew or open their mouth? _____

What is the main reason for your visit today? _____

Date and reason for last dental treatment _____

I authorize the Doctor to examine me (or my child) and obtain necessary diagnostic information.

Signed _____ Date _____

Reviewed Health History _____

Doctor

Date