**PATIENT INFORMATION**

Mr. Mrs. Ms. Dr. First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I.\_\_\_\_ Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_ Soc. Sec. #\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_

Home Tel. (\_\_\_)-\_\_\_\_\_\_-\_\_\_\_ Work Tel. (\_\_\_)- \_\_\_\_\_-\_\_\_\_\_ Cell Tel. (\_\_\_)-\_\_\_\_\_-\_\_\_\_\_ Preference \_\_\_\_\_\_

Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of an emergency, please contact\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel. (\_\_\_)-\_\_\_\_\_-\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY DENTAL INSURANCE COMPANY**

Ins. Co. Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I.D. # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_ Soc. Sec. #\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_

**SECONDARY DENTAL INSURANCE COMPANY**

Ins. Co. Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I.D. # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_ Soc. Sec. #\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_

**MEDICAL INFORMATION**

**CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR CURRENTLY HAVE:**

|  |  |  |
| --- | --- | --- |
| * Hepatitis A, B, C, D
 | * Bruise Easily
 | * Radiation / Chemotherapy
 |
| * Heart Condition
 | * Shortness of Breath
 | * Alcoholism / Addiction
 |
| * High Blood Pressure
 | * Swelling of Ankles
 | * HIV / AIDS
 |
| * Rheumatic Fever
 | * Artificial Joint\*
 | * Venereal Disease
 |
| * Anemia / Hemophilia
 | * Lung Disease / Emphysema
 | * Tuberculosis (TB)
 |
| * Diabetes
 | * Thyroid Disease
 | * Asthma / Hay Fever
 |
| * Herpes / Cold Sores
 | * Ulcers / Digestive Disease
 | * Sinusitis / ENT
 |
| * Heart Attack / Stroke
 | * Migraines / Headaches
 | * Skin Rash / Hives
 |
| * Heart Surgery
 | * Epilepsy / Fainting / Seizures
 | * Sickle Cell Disease
 |
| * Heart Murmur
 | * Glaucoma\* / Visual Disease
 | * Liver Disease
 |
| * Artificial Heart Valve
 | * Mental / Neural Disease
 | * Blood Transfusion
 |
| * Heart Pacemaker
 | * Tumor / Cancer
 | * Arthritis / Rheumatism
 |

List any diseases, conditions or problems not shown above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all medicine or drugs you are presently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **CHECK ALL THAT APPLY:**

* Are you allergic to any medicine, drugs, or other substance? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Are you under the care of a physician? Date of last visit:\_\_\_\_-\_\_\_\_-\_\_\_\_\_\_

If so, for what are you being treated?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physicians Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel.(\_\_\_\_)-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_

* Have you ever been hospitalized or had a surgery in the past five years?
* Have you ever had a reaction to local anesthetic (Lidocaine)?
* Have you ever had prolonged bleeding?
* Have you ever had complications following dental treatment?
* Have you ever had injury or trauma to your face?
* Are you required to pre-medicate prior to dental treatment?

**WOMEN ONLY:**

* Is there a possibility of pregnancy? Expected delivery date:\_\_\_\_-\_\_\_\_-\_\_\_\_\_\_\_
* Are you nursing?
* Are you taking birth control?

\*Note: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding other methods of birth control.

**PLEASE SIGN:**

**I certify** that I have read and understand the questions above. I acknowledge that my questions, if any, about the inquires set forth have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

**I hereby acknowledge that a copy of this office’s Notice of Privacy Practices has been made available to me**. I have been given the opportunity to ask any question I may have regarding this Notice.

**X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **X** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient (Parent or Guardian of Minor) Date