PLEASE COMPLETE THE FOLLOWING INFORMATION:

PATIENT INFORMATION: **DATE: _____**

LAST NAME: _____ FIRST: _____ MI: _____

ADDRESS: _____ SEX: _____ Are you a new patient? _____

CITY: _____ STATE: _____ ZIP:_____ DL#: _____ AGE: ____

HOME PHONE: _____ WORK PHONE: _____

EMPLOYER: _____ SS#: _____ DATE OF BIRTH: _____

SPOUSE'S NAME: _____ SS#: _____ DATE OF BIRTH: _____

REFERRED BY: _____ ALLERGIES: _____

PERSON TO CONTACT IN CASE OF EMERGENCY: _____ PH: _____

Is another member of your family, or relative a patient at our office?

_____

When was the last time you saw a Dentist? _____

IF YOU WISH TO FILE INSURANCE: SUPPLY OUR OFFICE WITH YOUR EMPLOYER'S INS. FORM THEN ANSWER THE FOLLOWING:

PRIMARY INSURANCE COMPANY NAME: _____ GROUP #: _____

POLICY HOLDER (employee): _____ EMPLOYER: _____

PREV: _____ % BASIC: _____% MAJOR: _____% ORTHO: _____% DED: _____ ANNUAL _____

SECONDARY INSURANCE COMPANY NAME: _____ GROUP # _____

POLICY HOLDER (employee): _____ EMPLOYER: _____

PREV: _____ % BASIC: _____% MAJOR: _____% ORTHO: _____% DED: _____ ANNUAL _____

FILL IN INFO AS IT APPLIES TO YOUR SPOUSE OF IF A MINOR, THE RESP. PARTY:

NAME OF SPOUSE OR RESP. PARTY: _____

ADDRESS: _____ Are you a patient? _____

CITY: _____ STATE: _____ ZIP:_____ DL#:__ _____

HOME PHONE: _____ WORK PHONE: _____

EMPLOYER: _____ SS#: _____ DATE OF BIRTH: _____

PATIENT'S RELATIONSHIP TO RESP. PARTY: Self ☐ Spouse ☐ Child ☐ Other ☐

MEDICAL HISTORY

Attending physician: _____ Phone #:_____

Are you presently taking any medication? _____

If so please list: _____

_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING MEDICATIONS? (Please Check)

☐ Aspirin	☐ Nitrous Oxide	☐ Valium	☐ Penicillin
☐ Darvon	☐ Erythromycin	☐ Scopolamine	☐ Other antibiotics
☐ Codeine	☐ Tetracycline	☐ Local anesthetic	☐ Novacaine or Xylocaine
☐ Demerol	☐ Percodan	☐ Nembutal / Seconal	☐ Sleeping pills

Are you aware of being allergic to any other medication or substance? _____

If so please list: _____

_____

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT THE PRESENT:

☐ Heart failure	☐ Emphysema	☐ Artificial Joints (hip, knee)
☐ Heart disease or attack	☐ Cough	☐ Hepatitis A (infectious)
☐ Angina Pectoris	☐ Tuberculosis (TB)	☐ Hepatitis B (serum)
☐ Kidney trouble	☐ Glaucoma	☐ HIV
☐ Ulcers	☐ Fever blisters	☐ Aids
☐ High Blood Pressure	☐ Asthma	☐ Liver Disease
☐ Heart Murmur	☐ Hay Fever	☐ Yellow Jaundice
☐ Rheumatic Fever	☐ Sinus Trouble	☐ Blood Transfusion
☐ Congenital Heart Lesions	☐ Allergies or Hives	☐ Drug Addiction
☐ Scarlet Fever	☐ Diabetes	☐ Hemophilia
☐ Artificial Heart Valve	☐ Thyroid Disease	☐ Cold Sores
☐ Heart Pacemaker	☐ X-Ray or Cobalt Tx	☐ Psychiatric Treatment
☐ Heart Surgery	☐ Arthritis	☐ Epilepsy or Seizures
☐ Anemia	☐ Rheumatism	☐ Fainting or Dizzy spells
☐ Stroke	☐ Cortisone Medicine	☐ Nervousness
☐ Bruise Easily	☐ Pain in Jaw Joints	☐ Sickle Cell Disease
☐ Chemotherapy (Cancer, leukemia)	☐ Veneral Disease (Syphilia, Gonorrhea	

For women only: Are you pregnant? _____ *Are you taking birth control pills?* _____

Comments:_____

_____

_____

Patient's Signature: _____ Date: _____

Signature of Responsible Party if Patient is a minor: _____