

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 INSURANCE CARD THEN ANSWER THE FOLLOWING:
PRIMARY INSURANCE COMPANY NAME: _____	
GROUP #: _____ MEMBER ID: _____ INS PHONE: _____	
POLICY HOLDER: _____ EMPLOYER: _____	
SECONDARY INSURANCE COMPANY NAME: _____	
GROUP #: _____ MEMBER ID: _____ INS PHONE: _____	
POLICY HOLDER: _____ EMPLOYER: _____	

FILL IN INFO AS IT APPLIES TO YOUR SPOUSE OR IF A MINOR, THE RESPONSIBLE 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 <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>

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)

- | | | | |
|----------------------------------|--|---|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> Valium | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Darvon | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Scopolamine | <input type="checkbox"/> Other antibiotics |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Local anesthetic | <input type="checkbox"/> Novacaine or Xylocaine |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Percodan | <input type="checkbox"/> Nembutal / Seconal | <input type="checkbox"/> 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:

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