# Patient Information
(Please Print)

Name ______________________________ Birthdate ______________
First Last

Address ______________________ City ____________ State _____ Zip ________

Patients Employer and Address ________________________________________

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Whom may we thank for referring you? ________________________________

# Insurance Information

Name of Insured ____________________ Relationship to patient ____________________

Birthdate ______ Social Security Number ______________ Work Phone ______________

Employer Name and Address ________________________________________

Insurance Company ______________________________ Group # ______________

*For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note additional questions concerning your health may be asked.*

Are you in good health? Yes No

Any change in your general health within the past year Yes No

Are you now under the care of a physician Yes No

If so, what is the condition being treated ______________

The name and address of my physician(s) ______________

________________________________

Are you taking any medication(s) including any non-prescriptive medication (aspirin, motrin-daily) Yes No

If so, what medications are you taking ______________

________________________________

________________________________

Do you have or have you had any of the following diseases or problems:

- Damaged heart valves or Heart Murmur Yes No
- In born heart defect Yes No
- Rheumatic heart disease Yes No
- Cardiovascular disease Yes No
- Heart trouble, Heart attack, Angina or Stroke Yes No
- High blood pressure Yes No

Do you have a cardiac pacemaker Yes No

- Sinus Trouble Yes No
- Fainting spells or seizures Yes No
- Diabetes Yes No
- Hepatitis Yes No
- AIDS or HIV infection Yes No
- Thyroid Problems Yes No
- Artificial Joints Yes No
- Respiratory problems, Emphysema, or Bronchitis Yes No
- Kidney Trouble Yes No
- Tuberculosis Yes No
- Sexually transmitted diseases Yes No
- Epilepsy Yes No
- Other neurological diseases Yes No
- Cancer Yes No

Have you had abnormal bleeding Yes No

Have you ever required a blood transfusion Yes No

Do you have any blood disorder such as anemia Yes No

Have you had treatment for a tumor or growth Yes No

Are you allergic or have you had a reaction to:

- Local anesthetics Yes No
- Penicillin or other antibiotics ____________ Yes No
- Sulfa drugs Yes No
- Codeine or other narcotics Yes No
- Other allergies ______________________

Have you ever had any serious trouble associated with any previous dental treatment Yes No

Do you have any disease, condition or problem not listed above ______________ Yes No

Women

- Are you pregnant or nursing Yes No
- Are you taking birth control pills Yes No

Brief Dental History or Complaint ______________

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

Signature ______________________________ Date ______________________________