PATIENT INFORMATION

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: M F SS#: _____-_____-_____ Single Married Divorced Widow

Mailing Address: _____ City:_____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Email: _____

Name of Responsible Party: _____

Employer: _____ Occupation: _____

How did you hear about our office? Newspaper Internet Mail Referral Other _____

Emergency Contact:

Name:_____ Relationship: _____ Phone: _____

Insurance Information:

Do you have dental insurance? **Yes No** Do you have Secondary Insurance? **Yes No**

	Primary Insurance		**Secondary Insurance**
Policy Holder Name		Policy Holder Name	
Policy Holder SSN		Policy Holder SSN	
Patient Relationship		Patient Relationship	
Employer Name		Employer Name	
Employer Phone #		Employer Phone #	
Insurance Company		Insurance Company	
Insurance Group #		Insurance Group #	
Member ID #		Member ID #	
Insurance Phone #		Insurance Phone #	
Insurance Billing Address		Insurance Billing Address	

****PLEASE PRESENT INSURANCE CARD AND PHOTO ID TO FRONT DESK TO BE PHOTOCOPIED****

I certify that I have read and understand the above information to the best of my knowledge. The health questions have been accurately answered. I understand providing incorrect information can be dangerous to my health. I authorize the dentist to release information including diagnosis, records of any treatment or examination of me or my dependent during the period of dental care to a third party payor and/or healthcare practitioners. I authorize and request my insurance company to pay directly to the dentist. I understand that if my dental insurance pays me directly, I am responsible for turning that money over to the dental practice. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand it is my sole responsibility to keep the dental office updated on my insurance carrier, if I do not, I understand I will be responsible for payment of all services provided myself and dependents.

X_____ Date: _____

Signature of Patient, Parent, or Guardian

PATIENT HEALTH HISTORY

Purpose of your visit? _____

Date of your last dental visit: _____ Dr. Name: _____

Any Complications from past dental treatment? _____

Do you have any existing partials? YES NO Upper/Lower How old are they: _____

Any existing dentures? YES NO Upper/Lower How old are they: _____

Facial Esthetics Interest:

Are you concerned about any lines, folds, or wrinkles on your face? YES NO

Would you be interested in learning about Botox or Fillers? YES NO

Are you concerned about misaligned, crowded, or spaces between your teeth? YES NO

Would you be interested in learning about Braces or Invisalign? YES NO

Medications:

Are you allergic to any medications? YES NO If yes, What? _____

Are you taking Pre-medication? If yes, Why? _____

Are you or have you taken Oral or IV Bisphosphonates?ie:Fosamax, Actonel, Zometa, Aredia? YES NO When?_____

List of medications:_____

_____

Physicians Name: _____ Phone #: _____

Date of your last medical checkup: _____

WOMEN: Are you pregnant? YES NO If yes, when is your due date? _____

Do have you a history:	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
AIDS/HIV +	Y	N	Endocarditis	Y	N	Organ Transplant	Y	N
Alzheimer's Disease	Y	N	Emphysema	Y	N	Osteoporosis	Y	N
Anemia	Y	N	Epilepsy/Seizure	Y	N	Parathyroid Disease	Y	N
Angina	Y	N	Excessive Thirst	Y	N	Psychiatric Care	Y	N
Arthritis	Y	N	Fainting/Dizzy/Vertigo	Y	N	Rheumatic Fever	Y	N
Artificial Heart Valve	Y	N	Heart Attack	Y	N	Rheumatism	Y	N
Artificial Joint Year:	Y	N	Heart Trouble/ Disease/Surgery	Y	N	Stroke Year:	Y	N
Asthma/COPD	Y	N	Heart Stents	Y	N	Scarlet Fever	Y	N
Autoimmune Disease	Y	N	Pacemaker	Y	N	Shingles	Y	N
Blood Disease/ Disorder	Y	N	Hepatitis A, B, C	Y	N	Sinus Trouble	Y	N
Cancer	Y	N	Herpes	Y	N	Stomach Disease	Y	N
Chemo/Radiation	Y	N	Frequent Headaches	Y	N	Sleep Apnea	Y	N
Cold Sores	Y	N	Hypoglycemia	Y	N	Thyroid Disease	Y	N
Congenital Heart D/O	Y	N	High Blood Pressure	Y	N	Tonsillitis	Y	N
Convulsions	Y	N	Kidney Problems	Y	N	Unexplained Weight Loss	Y	N
Diabetes TYPE 1 or 2	Y	N	Leukemia	Y	N	Tuberculosis	Y	N
Drug/Alcohol Addiction	Y	N	Liver Disease/Dialysis	Y	N	Tumors/Growths	Y	N
Dry Mouth	Y	N	Lung Disease	Y	N	Ulcers	Y	N

Any other illnesses not listed above? _____