

PATIENT & MEDICAL HISTORY

Date: _____ **Who May We Thank For Referring You?** _____

Cell Phone: _____ **Home Phone:** _____ **Business Phone:** _____

Patient: _____ **Social Security No:** _____
Last Name First Name Initial Preferred Name

Address: _____ **Email:** _____

Sex: M F **Birth Date:** _____ **Age:** _____ Single Married Divorced Widow
Apt. # City State Zip

INSURANCE INFO: **Insurance Co.:** _____ **Policy/Plan No:** _____
Policy Holder's Name: _____ **Relation to Patient:** Self Spouse Child
Birthdate: _____ **Social Security No:** _____
Employer/Company: _____ **Position/Occupation:** _____
Address: _____
Ste. # City State Zip

(Only for those with dual insurance coverage.)

SECONDARY INSURANCE INFO: **Insurance Co.:** _____ **Policy/Plan No:** _____
Policy Holder's Name: _____ **Relation to Patient:** Self Spouse Child
Birthdate: _____ **Social Security No:** _____
Employer/Company: _____ **Position/Occupation:** _____
Address: _____
Ste. # City State Zip

MEDICAL INFORMATION

Physician's Name: _____ **Date of Last Physical:** _____

Do you have or have you had any of the following?

		Yes	No			Yes	No			Yes	No
Heart Problems				Recent Weight Loss				Back Problems			
High Blood Pressure				Asthma				Alcohol/Drug Addiction			
Artificial Heart Valves				Low Blood Pressure				Stroke			
Artificial Joints				Circulatory Problems				Ulcer			
Allergic to Penicillin				Epilepsy				Venereal Disease			
Hepatitis - A <input type="checkbox"/> or B <input type="checkbox"/>				Headaches				History of taking Fen/Phen			
Allergies to Anesthetics/Latex				Cancer				Hemophilia			
Rheumatic Fever				Radiation Treatment				Diabetes			
HIV or AIDS				Blood Disease				Thyroid Conditions			

If you marked yes to any of the above, please explain. _____
 Any disease or condition you have or have had but is not listed above? _____
 Have you been hospitalized in the last 5 years? Yes No Explain: _____
 Any medication you are currently using? _____
 Any allergies or strong reaction to any medication? _____
 Are you pregnant now (women only) ? Yes No If yes, due date: _____

DENTAL INFORMATION

Why are you here to see the dentist today? _____
 When was your last dental visit? _____ What was done? _____
 Name of Previous Dentist/Dental Clinic: _____ Phone Number: _____

HOW WILL YOU BE PAYING TODAY? CASH CHECK CREDIT CARD

The above information is accurate and complete to the best of my knowledge and is for use in my treatment, billing and processing of insurance benefits to which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors which may result from insufficient/misleading information given on this form.

Patient's Signature: _____ **Date:** _____
Doctor's Signature: _____ **Date:** _____