Today's Date: _____

Name: _____ _____ Male Female
Last First Mi Preferred Name

Birth Date: _____ **Age:** _____ **Social Security #:** _____

Home Address: _____
Street City State Zip

Home Phone #: (_____) _____ **Cell Phone #:** (_____) _____

Work Phone #: (_____) _____ **E-mail Address:** _____

Employer: _____ **Driver License #:** _____

Whom may we thank for referring you? _____

| Neighbor or Relative not living with you to contact in case of Emergency |

His/Her Name: _____ Relation: _____ Phone #: _____

| Person Responsible for Account if other than yourself |

Name: _____ Relation: _____ Home Phone #: _____

Social Security #: _____ Employer: _____ Work Phone #: _____

Billing Address: _____
Street City State Zip

| Spouse Information |

His/Her Name: _____ Birthdate: _____ Social Security #: _____

Phone #: _____ Employer: _____ Work Phone #: _____

| Insurance Information |

Insurance Co. Name: _____ Phone #: _____ Group #: _____

Insurance ID #: _____ Insured's Employer: _____

Insurance Co. Address: _____
Street City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: _____

| General Dentist |

General Dentist: _____ Date of Last Visit: _____

Phone #: (_____) _____

| Dental/Health History |

Do you require antibiotics before dental treatment? **Y** or **N**

Your current dental health is: Good Fair Poor Do you floss daily? **Y** or **N**

Have you ever had orthodontic treatment? **Y** or **N** When: _____ Name of orthodontist: _____

Have your Wisdom Teeth been removed? **Y** or **N** When: _____ Name of oral surgeon: _____

What is your main concern? _____

Physician _____ Phone #: _____ Last visit: _____

Please list all medications you are currently taking: _____

_____

Allergies: _____
(Foods / Medications / Latex Gloves / Unknown)

Have you ever been hospitalized? **Y** or **N** Explain:

_____

(Females) Are you: Taking birth control pills? **Y** or **N** Pregnant?: **Y** or **N** Nursing?: **Y** or **N**

Please check YES or NO to any of the following conditions that apply to you:

Y N (please check)	Y N (please check)	Y N (please check)	Y N (please check)
Accidents	ADD / ADHD	Anemia	Arthritis, Rheumatism
Artificial Heart Valves	Artificial Joints	Asthma or Hay Fever	Autism
Blood Disease	Cancer	Chemical Dependency	Chemotherapy
Circulatory Problems	Cyst / Infection	Diabetes / Blood Sugar	Difficulty Breathing
Epilepsy	Fainting-Seizures-Convulsions	Frequent Cold Sores, Canker Sores	Glaucoma
Headaches - Migraines	Hearing Loss	Heart Murmur	Heart Problems
Hemophilia	Hepatitis / Jaundice	High or Low Blood Pressure	HIV Positive / AIDS
Kidney or Bladder	Liver Disease	Mitral Valve Prolapse	Pacemaker
Radiation Treatment	Rehabilitation Drugs/Alcohol	Respiratory Disease	Rheumatic Fever
Scarlet Fever	Stroke	Thyroid Problems	Tobacco Habit
Tuberculosis	Ulcer	Venereal Disease	

| Authorization |

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I understand that I am responsible for paying any co-payment and deductible my insurance does not cover.

It is my responsibility to advise the office of any changes in personal/medical status: Initials _____

Please sign that this information is accurate and complete:

Signature _____ Date _____

Received by Dr. _____ Date _____