

Patient Name: _____ Male:___ Female:___ Today's Date: _____ - _____ - _____
 Address: _____ City: _____ State: _____ Zip: _____
 Birthday: _____ - _____ - _____ Age: _____ Social Security # _____ - _____ - _____
 Home Phone: _____ - _____ - _____ Work Phone: _____ - _____ - _____ Cell Phone: _____ - _____ - _____
 Employer: _____
 Marital Status: Minor Single Married Divorced Widowed
 Parent/Spouse's Name: _____

Primary Dental Insurance

Company Name: _____ Policy Holder's Name: _____
 Policy Holder's Birthday: _____ - _____ - _____ Policy Holder's Social Security Number: _____ - _____ - _____
 Policy Holder's Employer: _____

Secondary Dental Insurance

Company Name: _____ Policy Holder's Name: _____
 Policy Holder's Birthday: _____ - _____ - _____ Policy Holder's Social Security Number: _____ - _____ - _____

Are you allergic to any of the following?

- Aspirin
- Acrylic
- NO KNOWN ALLERGIES
- Penicillin
- Metal
- Codeine
- Latex
- Local Anesthetics
- Other: _____

Medical History

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

- AIDS/HIV
- Alzheimer's Disease
- Artificial Heart Valve/ Joints Year: _____
- Blood Thinners
- Cancer-date last treatment _____
- Chemotherapy/Radiation Therapy
- Diabetes
- Epilepsy/Seizures/Fainting
- Heart Attack-date _____
- Heart Murmur
- Heart Pacemaker
- Hepatitis A B C
- Herpes
- High/Low Blood Pressure
- Stroke
- Tuberculosis

- Have you taken or are you taking medication for Osteoporosis?
- Do you smoke/chew tobacco
- NO MEDICAL CONDITIONS**

Please list ALL medications:

Women's Health:

- Pregnant
- Taking Oral Contraceptive
- Nursing

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made. If all account is not paid within 90 days of the date service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collection of your account. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. ***I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.*** All of the information provided to our office will be kept confidential. I hereby authorize assignments of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by insurance.

X _____ **Date:** _____ - _____ - _____

Signature of patient (or parent/guardian if minor)