Patient's Name_____ DOB_____ Social Security #_____

(If a Child, Parent's Name)_____ Cell Phone#_____ Other Contact #_____

Mailing Address_____ City_____ ST_____ Zip_____

Name of Spouse_____ DOB_____ Spouse Contact Number_____

NAME OF PRIMARY INSURED_____ PRIMARY'S DOB_____ PRIMARY'S SS#_____

NAME OF DENTAL INSURANCE COMPANY_____ PRIMARY INSURED ID#_____

PRIMARY INSURED EMPLOYEER_____ Emergency Contact/#_____

CIRCLE ALL THAT APPLY BELOW:

A.I.D.S Angina Pectoris Alcoholism Arthritis Artificial Joints/Implants Artificial Heart Valve Asthma Bleeding Problems

Blood Transfusion Congenital Heart Lesions Cosmetic Surgery/Facial Fillers Chemotherapy Cancer/Tumor Drug Addiction Diabetes

Epilepsy/Seizure Fainting Dizzy Spells Fever Blisters High Blood Pressure Heart Disease/Attack Heart Murmur Heart Pacemaker Heart Surgery

Hepatitis A/ B Liver Disease Mitral Valve Prolapse Psychiatric Treatment Prescribed Diet Drugs Stroke Thyroid Disease Tuberculosis

Are you taking a Blood Thinner? _____ Osteoporosis Meds /Injections?_____

(Name of Drug) (Name of Drug)

ARE YOU ALLERGIC OR HAD REACTIONS TO ANY OF THE FOLLOWING:

Amoxicillin/Penicillin Clindamycin Ibuprofen Keflex Latex Local Anesthetic Nitrous Ultram ZPack OTHER_____

MEDICATIONS:_____

SURGERIES WITHIN THE LAST 5 YEARS:_____

IF UNDER CARE, PHYSICIANS NAME:_____ PREGNANT?_____ Tobacco Products?_____ Recreational drugs?_____

HIPAA CONTACTS NAME (optional)_____

Signature_____ Date_____ Referred by_____