Female ☐ Male ☐ Married ☐ Single ☐ Divorced ☐ Widower ☐ Widow ☐

Patient's Name _____ Date of Birth _____ Soc Sec # _____ DL# _____

If a Child, Parent's Name _____ Parent's Date of Birth _____ Parent's Soc Sec # _____

Mailing Address _____ City _____ State _____ Zip _____

Residence Phone _____ Business Phone _____ Cell Phone _____ Other Contact Number _____

Patient or Parent Employed by _____ Business Address _____ How Long? _____

Name of Spouse _____ Spouse Employed by _____ Business Phone _____

Spouse Date of Birth _____ Spouse Soc Sec # _____ Person Responsible for Account _____

Name of Dental Insurance Company _____ Name of Person Insured _____ Insured Soc Sec # _____

Insured Date of Birth _____ Insurance Co Phone # _____ Group # _____ Policy # _____ ID # _____

**If no dental insurance, payment is due at time services are rendered.*

DO YOU HAVE OR HAVE YOU EVER HAD:

	YES	NO		YES	NO		YES	NO		YES	NO
Mitral Valve Prolapse	☐	☐	Anemia	☐	☐	Epilepsy or Seizures	☐	☐	Prescribed Diet Drugs	☐	☐
Heart Failure	☐	☐	Stroke	☐	☐	Fainting / Dizzy Spells	☐	☐	Fever Blisters	☐	☐
Heart Disease/Attack	☐	☐	Chemotherapy	☐	☐	Nervousness	☐	☐	Diabetes	☐	☐
Angina Pectoris	☐	☐	Cancer, Tumor	☐	☐	Psychiatric Treatment	☐	☐	Thyroid Disease	☐	☐
High Blood Pressure	☐	☐	A.I.D.S. – HIV positive	☐	☐	Sickle Cell Disease	☐	☐	X-Ray / Cobalt Treatment	☐	☐
Heart Murmur	☐	☐	Hepatitis A (Infectious)	☐	☐	Glaucoma	☐	☐	Arthritis	☐	☐
Rheumatic Fever	☐	☐	Hepatitis B(Serum)	☐	☐	Bleeding Problems	☐	☐	Rheumatism	☐	☐
Congenital Heart Lesions	☐	☐	Liver Disease	☐	☐	Cosmetic Surgery	☐	☐	Cortisone Medicine	☐	☐
Scarlet Fever	☐	☐	Yellow Jaundice	☐	☐	Bruise Easily	☐	☐	Pain in Jaw Joints	☐	☐
Artificial Heart Valve	☐	☐	Blood Transfusion	☐	☐	Emphysema	☐	☐	Alcoholism	☐	☐
Heart Pacemaker	☐	☐	Drug Addiction	☐	☐	Tuberculosis (TB)	☐	☐	Ulcers	☐	☐
Heart Surgery	☐	☐	Hemophilia	☐	☐	Allergies or Hives	☐	☐	Venereal Disease	☐	☐
Artificial Joints, Implants	☐	☐	Kidney Trouble	☐	☐	Asthma	☐	☐	(Syphilis, Gonorrhea, etc)		

Date of Last Medical Exam _____ Name of Physician _____ Are you under the care of a Physician now? _____

Are you Taking Medication? _____ If yes, What? _____ **Are You, or Could You be Pregnant?** _____

Are you allergic to or have you reacted adversely to any of the following medications: (please circle)

Aspirin Percodan Erythromycin Darvon Local Anesthetic Valium Nitrous Oxide Codeine Penicillin Latex Other

Any Other Physical Conditions _____ Emergency Contact _____ Phone # _____

Last Dental Visit _____ Last Dental X-rays _____ Are Your Teeth sensitive to Hot, Cold or Pressure? _____ Ever Been Diagnosed with Gum Disease? _____

Do You, or Have You Used Tobacco Products? _____ Recreational Drugs? _____ Alcohol? _____ Referred by _____

Signature _____ Date _____ Email Address _____