Patient Information

Name:		Today's Date:	
Address:		Referred By:	
City:		Sex:	Male Female
Zip Code:		Birth date:	
Telephone:		Height:	
Alternative Phone:		Weight:	
Social Security:		Martial Status:	
Employer:		Spouse's Name:	
Employer Number:		Spouse's Number:	
Occupation:			

Individual Responsible for Billing (leave blank if the same as above)

Name:		Sex:	Male Female
Address:		Social Security:	
City:		Employer:	
Zip Code:		Employer Number:	
Telephone:		Occupation:	
Alternative Phone:			

Patient's Emergency Contact

Name:	
Telephone:	
Alternative Phone:	
Relationship:	

Medical Physician

Name:	
Telephone:	

Medical History

(Please Select Applicable Answer)

1.) Your general health is?

2.) Is a doctor currently treating you? Y N

3.) Any health changes in the past year? Y N

4.) Have you been hospitalized or had surgery in the last 5 years? Y N
reason?

5.) Have you had a blood transfusion? Y N

6.) Have you had a facial or jaw injury? Y N

7.) Have you had treatment for a tumor? Y N

8.) Are you ever short of breath? Y N

9.) Do you ankles ever swell? Y N

10.) Could you be pregnant? Y N

11.) Have you ever used diet drugs? Y N

12.) Do you use tobacco products? Y N
How often?

13.) Do you need a dental Premed? Y N

14.) Are you or have you taken bone density medictation? Y N
Type?

15.) Are you taking blood thinning medicaton? Y N
Type?

Have you had any of the following?

CONDITION		ONSET DATE	CONDITION		ONSET DATE
AIDS	Y N		High Blood Pressure	Y N	
Anemia	Y N		HIV+	Y N	
Arthritis	Y N		Implant	Y N	
	Y N		(if so, what type?)		
(if so, what type?)			Kidney	Y N	
Bleeding Disorder	Y N		Psychiatric Disorder	Y N	
Cancer	Y N		Seizures	Y N	
(if so, what type?)			Stroke	Y N	
Hearing Loss	Y N		Thyroid Disorder	Y N	
Heart Attack	Y N		Tuberculosis	Y N	
Heart Murmur	Y N		Ulcer	Y N	
Hepatitis	Y N		Stents	Y N	

Allergies:

Reactions:

List Current Medications:

Insurance Information

Do you have dental insurance? Y N **Would you like to set-up payment arrangements?** Y N

Primary Insurance Name:		**Secondary Insurance Name:**	
Employer Name:		**Employer Name:**	
Employee Name:		**Employee Name:**	
ID#:		**ID#:**	
Employee Birth date:		**Employee Birth date:**	
Group or Policy Number:		**Group or Policy Number:**	

AUTHORIZATION

understand any amount not covered by insurance or if I do not have insurance covereage is my responsibility to pay the charged amount. The above dental and medical histories, the personal and insurance information are all correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and personal information to third party payers and/or other health professionals.

SIGNATURE **DATE**

Notice of Privacy Practices - Acknowledgement

We keep record of the dental/health care services we provide to you. You may ask to see and copy that record. You may ask to correct that record. We will not disclose your record to others unless you direct us to do so, we refer you to another provider or unless the law authorizes

Our Notice of Privacy Practices describes ub nire detail how your health information may be used and disclosed and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

PRINTED PATIENT NAME

DATE

TIME

PATIENT'S SIGNATURE

SIGNING ON BEHALF OF PATIENT

RELATIONSHIP TO PATIENT