I. PATIENT INFORMATION

HOW DID YOU FIND OUT OUR OFFICE? _____

Please Check
MARRIED ☐
SINGLE ☐
DIVORCED ☐
WIDOWED ☐
CHILD ☐

MR MS MRS MISS | LAST NAME | FIRST NAME | MIDDLE NAME

STREET ADDRESS

CITY | ZIP CODE

HOME PHONE ( ) | CELL PHONE ( ) | WORK PHONE ( )

BIRTHDAY | AGE | S.S. #

DRIVER'S LICENSE NUMBER | PLEASE CIRCLE MALE / FEMALE | HOW LONG EMPLOYED?

EMPLOYER NAME | OCCUPATION

EMPLOYER ADDRESS | CITY | ZIP CODE

FRIEND | NEAREST RELATIVE NOT LIVING WITH YOU | PHONE #

RELATIONSHIP TO PATIENT
PARENT ☐ LEGAL GUARDIAN ☐ STEPPARENT ☐ OTHER _____

II. INSURANCE INFORMATION PARENT/RESPONSIBLE PARTY

INSURED EMPLOYEE (PRIMARY)

MR MS MRS MISS | LAST NAME | FIRST NAME | MIDDLE NAME

SOC. SEC. # (INSURED EMPLOYEE) | NAME OF EMPLOYER/COMPANY

DRIVER'S LIC # INSURED EMPLOYEE | EMPLOYER ADDRESS | CITY | STATE

INSURANCE CO (CARRIER) | EMPLOYER PHONE ( ) | DATE OF HIRE

PLAN / GROUP NUMBER | LOCAL NUMBER | *DOB OF INSURED PERSON*

III. DUAL INSURANCE INFORMATION

(Complete if you or your spouse have additional insurance coverage)

PLEASE CIRCLE
MALE ☐
FEMALE ☐

INSURED EMPLOYEE (SECONDARY)

MR MS MRS MISS | LAST NAME | FIRST NAME | MIDDLE NAME

SOC. SEC. # (INSURED EMPLOYEE) | NAME OF EMPLOYER/COMPANY

DRIVER'S LIC # (INSURED EMPLOYEE) | EMPLOYER ADDRESS | CITY | STATE

INSURANCE CO (CARRIER) | EMPLOYER PHONE ( ) | DATE OF HIRE

PLAN GROUP NUMBER | LOCAL NUMBER | DOB OF INSURANCED PERSON

IV. GENERAL HEALTH INFORMATION

1.- Are you under a doctor's care at this time? YES NO If yes, please specify _____
Physician's name and phone number _____
2.- Are you allergic to penicillin, codeine, sulfa, local anesthetics tranquilizers or any other drugs or medicine? YES NO
3.- Are you taking any medication at this time? YES NO If yes, please specify _____
4.- (Women) Are you pregnant at this time? YES NO If yes, please specify how many months _____
5.- Bisphosphonate usage (Boniva/Fosamax/Reclast YES NO
6.- Prosthetic Implants YES NO
7.- Please check any condition you now have had and indicate if active or passive.
8.- Are you under dialysis? YES NO

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS	☐	☐	DIABETES	☐	☐	HEART BYPASS	☐	☐	LOW BL. PRESSURE	☐	☐
ALLERGIES	☐	☐	DIZZY SPELLS	☐	☐	HEART MURMUR	☐	☐	LUNG DISEASE	☐	☐
ANEMIA	☐	☐	EMPHYSEMA	☐	☐	HEART PROBLEMS	☐	☐	RHEUMATIC FEVER	☐	☐
ANGINA	☐	☐	EPILEPSY	☐	☐	HEPATITIS	☐	☐	SINUS TROUBLE	☐	☐
ARTHRITIS	☐	☐	FAINTING	☐	☐	HIGH BL. PRESSURE	☐	☐	STROKE	☐	☐
ASTHMA	☐	☐	FEVER BLISTERS	☐	☐	JAUNDICE	☐	☐	THYROID PROBLEMS	☐	☐
CANCER	☐	☐	GLAUCOMA	☐	☐	KIDNEY DISEASE	☐	☐	TUBERCULOSIS	☐	☐
COLD SORES	☐	☐	HEART ATTACK	☐	☐	LIVER PROBLEMS	☐	☐	VENEREAL DISEASE	☐	☐

V. DENTAL INFORMATION

1.- Why are you here today? Check-Up ☐ Cleaning ☐ Toothache ☐ Other _____
2.- When did you last visit a dentist? 3.- What treatment was performed? _____
4.- Was the treatment completed? _____ 5.- Did you have a cleaning? _____ 6.- When were dental X-rays last taken? _____
7.- Have you ever had prolonged bleeding? YES NO
8.- Have you had any problems with past dental treatment? YES NO If yes, please specify _____
9.- Do your gums bleed easily? YES NO 10.- Do you feel you have bad breath? YES NO 11.- Are your teeth sensitive to hot or cold? YES NO
12.- Are you Allergic to latex? YES NO 13. Have you taken phen phen? YES NO

I have filled out this health questionnaire completely and I have advised you of all medical problems of which I am aware. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other dentist is responsible for my dental treatment. I understand that I am personally responsible for the cost of my dental care. I agree to pay for any dental work rendered by this office if for any reason whatsoever my insurance coverage denies liability, and I will notify this office of any change in eligibility for insurance coverage. If in default of the above agreement on my part necessitates legal action. I shall assume all responsibility for interest, principal and reasonable attorney fees.

DATE _____

_____
SIGNATURE OF PATIENT/PARENT/GUARDIAN

My dental treatment and possible alternatives have been discussed with me. I have been informed of all risks involved with my dental care and local anesthesia, including possible blood loss and infection. I hereby consent to the administration of local anesthesia and the dental treatments specified by the diagnosing doctor.

_____ / / _____ _____ / / _____
SIGNATURE OF DOCTOR | DATE | SIGNATURE OF PATIENT | DATE