

Patient information

Name _____ Preferred name _____ Birth date _____

If a minor, parents' names _____ Home phone _____ Cell phone _____

Mailing address _____ City _____ State _____ ZIP _____

Email _____ Employer _____ Work phone _____

Spouse's name _____ Spouse's employer _____

How did you hear about us, or who referred you? _____ ☐ DD Waiver

INSURANCE

☐ Dental ☐ Medical ☐ SR plan ☐ Medicare ☐ Tricare ☐ PPO ☐ HMO

Insurance company _____ Group number _____ Social Security number _____

Covered by spouse's insurance? ☐ Yes ☐ No (skip the next line)

Spouse's insurance company _____ Group number _____

Spouse's birth date _____ Spouse's Social Security number _____

MEDICAL HISTORY

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

- | | |
|--|--|
| ☐ Cancer or tumor | ☐ Diabetes |
| ☐ Heart ailment or angina | ☐ Neurologic condition |
| ☐ Heart murmur, mitral valve prolapse, heart defect | ☐ Epilepsy, seizures, or fainting spells |
| ☐ Rheumatic fever or rheumatic heart disease | ☐ Emotional condition, anxiety |
| ☐ Artificial joint or valve | ☐ Arthritis |
| ☐ High or low blood pressure | ☐ Herpes or cold sores |
| ☐ Pacemaker | ☐ AIDS or HIV positive |
| ☐ Tuberculosis or other lung problems | ☐ Migraine or frequent headaches |
| ☐ Kidney disease | ☐ Anemia or blood disorders |
| ☐ Hepatitis or other liver disease | ☐ Abnormal bleeding after extractions, surgery, or trauma |
| ☐ Alcoholism | ☐ Hay fever or sinus trouble |
| ☐ Blood transfusion | ☐ Allergies or hives |
| | ☐ Asthma |

Are you allergic to, or have you reacted badly to, any of the following?

- ☐ Latex
- ☐ Penicillin or other antibiotics
- ☐ Local anesthetics (Novocain)
- ☐ Codeine or other narcotics
- ☐ Sulfa drugs
- ☐ Barbiturates, sedatives, or sleeping pills
- ☐ Aspirin

Other _____

Do you smoke or use chewing tobacco? ☐ Yes ☐ No

Are you taking any of the following?

- | | | |
|--|---|---|
| ☐ Aspirin | ☐ High blood pressure medicine | ☐ Nitroglycerin |
| ☐ Anticoagulants (blood thinners) | ☐ Antidepressants or tranquilizers | ☐ Cortisone or other steroids |
| ☐ Antibiotics or sulfa drugs | ☐ Insulin, Orinase, or other diabetes drug | ☐ Osteoporosis (bone density) medicine |

Other _____ Women: ☐ May be pregnant ☐ Taking contraceptives Expected delivery date _____

Any other disease, condition, or problem _____

Emergency contact _____ Phone _____

INSURANCE BENEFITS AND PAYMENT

By signing below, I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges not paid by insurance.

Signature of patient or parent _____ Date _____