Name ______________________________ Preferred Name ______________
(last) (first) (middle)

Address ______________________________ Home Telephone ______________

City ______________ State ______ Zip ______ Work Telephone ______________

E-mail ______________________________ Cell Phone ______________

Date of Birth ____________ Sex ______ Social Security No. ______________

Employer ______________________________ Occupation ______________

Dental Insurance Co. ______________________________ Group Number ______________

Address of Ins. ______________ City ______________ State ______ Zip ______

Insurance Co. Telephone ______________________________

In an emergency, please contact ______________ Relationship ______________

Address ______________ City ______________ State ______ Zip ______

Home Telephone Number ______________ Work Telephone Number ______________

Whom may we thank for referring you to our office? ______________________________

SPOUSE OR PARENT'S INSURANCE INFORMATION

Spouse/Parent ______________________________ Social Security No. ______________
(circle one) (last) (first) (middle)

Address ______________________________ Date of Birth ______________

City ______________ State ______ Zip ______ Home Telephone ______________

Employer ______________________________ Work Telephone ______________

Employer Address ______________ City ______________ State ______ Zip ______

Dental Insurance Co ______________________________ Group Number ______________

Address ______________ City/State/Zip ______________ Telephone ______________

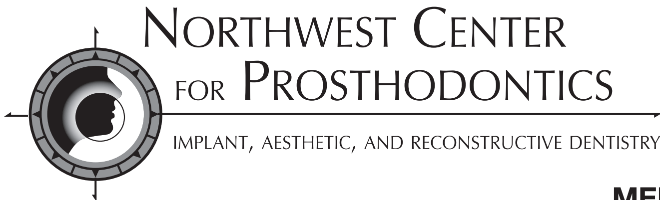
I authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I authorize my Doctor to submit claims for benefits for services rendered. I authorize payment directly to the Doctor of the insurance benefits otherwise payable to me. I understand that my insurance may not cover any or all of the fees for the professional services rendered and that I am responsible for payment of the entire bill.

______________________ ______________ ______________________ ______________
Signature of Insured Patient Date Signature of Spouse/Parent Date

APPOINTMENT INFORMATION

Best time for appointments ______________ Best time to telephone ______________

May we call you on short notice? ______________ Best telephone number ______________



MEDICAL HISTORY

Patient's name_______________________________ Date of birth _____________ Age ______

Physician's name_______________________________ Physician's Telephone _______________

Physician's address____

Are you presently under a physician's care? . . . . YES NO

For what reason? ____

Have you ever had a serious illness or operation? . . . . YES NO

If so, explain____

When was your last complete physical exam? _______________________

Are you presently taking any medications? . . . . YES NO

Medication	*Reason for taking*
____________________	______________________________
____________________	______________________________
____________________	______________________________
____________________	______________________________
____________________	______________________________

Are you allergic to any medications or substances? . . . . YES NO

If so, please list ____

Do you have any adverse reactions to antibiotics, anesthetics, or other medications? . . . . YES NO

Do you have a pacemaker or artificial heart valve? . . . . YES NO

Have you had an artificial joint placed in the past 2 years (ie: hip, knee, shoulder)? . . . . YES NO

Please check if you now have or have ever been treated for any of the following conditions:

☐ Heart disease	☐ Anemia	☐ Leukemia	☐ Cancer/Tumor
☐ AIDS/HIV positive	☐ Thyroid disorders	☐ High blood pressure	☐ Angina
☐ Lung problems	☐ Arthritis/rheumatism	☐ Glaucoma	☐ Psychiatric care
☐ Bleeding disorders	☐ Stomach problems	☐ Kidney problems	☐ Liver problems
☐ Diabetes	☐ Asthma	☐ Epilepsy or seizures	☐ Venereal disease
☐ Hepatitis	☐ Tuberculosis	☐ Low blood pressure	☐ Other

Have you ever smoked? YES NO Packs per day? ______ Date started ______ Date quit ______

Do you consume alcoholic beverages? YES NO If so, how much? ______________

Do you have any disease, condition, or health problem not listed? If so, please describe: ______________

____

____

WOMEN ONLY

Are you pregnant or do you suspect you may be? . . . . YES NO

Are you taking contraceptives or other hormones? . . . . YES NO

Have you reached menopause? . . . . YES NO

NOTES

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____

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Patient signature X _______________________________ Date ______________

UPDATED

Initials ______ Date ________ Initials ______ Date ________ Initials ______ Date ________

Initials ______ Date ________ Initials ______ Date ________ Initials ______ Date ________