PATIENT INFORMATION

Patient name _____ Today's date_____

Address _____ City/State _____ Zip _____

Home Phone _____Work Phone _____ Cell Phone _____

Email_____ _____ Preferred method of contact_____

May we leave a message on your voicemail or leave a message with a person? Yes____No____

SS#_____ Patient Date of Birth _____

Check appropriate box: Single ____Married ____Divorced ____Widowed ____Separated_____

Whom may we thank for referring you _____

<u>INSURANCE INFORMATION</u>:

Name of Policy Holder _____ Relationship to Patient_____

SS#_____ DOB_____ Name of Employer_____

Name of DENTAL Insurance Co_____ Group #_____

Insurance Co Address _____ City/State_____

Zip code_____ If required, Union or Local #_____

<u>SECONDARY DENTAL INSURANCE:</u>

Name of Policy Holder _____ Relationship to Patient_____

SS#_____ DOB_____ Name of Employer_____

Name of DENTAL Insurance Co_____ Group #_____

Insurance Co Address _____ City/State_____

Zip code_____ If required, Union or Local #_____

In the event that your account becomes past due, we may utilize a collection agency. In this case, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs, and expenses, including reasonable attorneys fees, we incur in such collection efforts. . If you have any questions, please discuss with our Scheduling Coordinator.

PATIENT MEDICAL HISTORY

Physician Name and Phone #_____

Emergency contact phone number OTHER THAN YOUR OWN NUMBER_____

1. **Are you currently under medical treatment? no_____ yes _____**
2. **Have you ever had any surgical operation or serious illness? no _____ yes_____**
3. **Are you taking any medications prescription or non-prescription? no _____ yes _____**
   If so, what?
   _____
4. **Do you use tobacco? no _____ yes _____**
5. **Do you use alcohol? no _____ yes _____**
6. **Have you had any allergic reactions to any of the following:**

Novocaine: no _____ yes _____	**Aspirin: no _____ yes ____**
Local Anesthetics: no _____ yes _____	**Sedatives: no _____ yes ____**
Penicillin: no _____ yes ____	**Other Antibiotics: no _____ yes ____**
Sulfa Drugs: no _____ yes ____	**Codeine: no _____ yes ____**

OTHER _____

7. **Do you have a persistent cough or throat clearing lasting more than 3 weeks?**
8. **Women only: Are you taking Birth Control Pills? no _____ yes _____**
   Are you pregnant or think you may be pregnant? no _____ yes _____
   Are you nursing? no _____ yes ____ _
9. **DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?**

_____High Blood Pressure	**_____Heart Disease/Trouble**	**_____Chest Pains**
_____Heart Attack	**_____ Pacemaker**	**_____ Winded Easily**
_____Heart Murmur	**_____ Rheumatic Fever**	**_____ Stroke**
_____Angina	**_____ Swollen Ankles**	**_____ General Allergies/Hayfever**
_____Endocarditis	**_____ Artificial Heart Valves**	**_____ Taking blood thinners**
_____Fainting	**_____ Seizures**	**_____Tuberculosis**
_____Frequently Tired	**_____ Asthma**	**_____ Radiation Therapy**
_____Anemia	**_____ Low Blood Pressure**	**_____ Recent Weight Loss**
_____Emphysema	**_____ Epilepsy/Convulsions**	**_____ Respiratory Problems**
_____Cancer	**_____ Leukemia**	**_____Glaucoma**
_____Arthritis	**_____ Diabetes**	**_____Liver Disease**
_____Joint Replacement	**_____ Kidney Disease**	**_____Stomach Ulcers**
_____Hepatitis/Jaundice	**_____ Thyroid Problems**	**_____ Sexually Transmitted Disease**

OTHER: _____

I certify that I have read and understand the above information to the best of my knowledge and the above questions have been accurately answered. I understand any incorrect info could be damaging to my health.

SIGNATURE_____DATE_____

Medical History Updates: Please review your medical history and let us know if there have been any changes since your last appointment, if you are taking any new medications, or have had a reaction to any medications.

SIGNATURE_____DATE_____

SIGNATURE_____DATE_____

SIGNATURE_____DATE_____