PATIENT INFORMATION

Name: _____ _____ _____ _____
Last First M.I. Nickname

Address: _____ City: _____ State: _____ Zip Code: _____

Sex: ____ M ____ F Date of Birth _____ Age _____ Social Security # _____

Home #: _____ Work #: _____ Cell #: _____

Employer : _____

Marital Status: Single - Married - Divorced - Widowed

Student: _____ Y _____ N If yes, where? _____

If child, parent's name: _____

Referring Dentist: _____ Medical Physician: _____

RESPONSIBLE PARTY INFORMATION – MUST BE PRESENT

*****The responsible party agrees to be responsible for payment of all services rendered*****

Responsible Party's Name: _____ Relationship: ____ Self ____ Spouse ____ Parent ____ Other

Date of Birth : _____ Responsible Party's Social Security # (Required) : _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home #: _____ Work #: _____ Cell #: _____

Employer: _____

INSURANCE INFORMATION

*****We will gladly file your primary dental and medical insurance for you.**
Please note that you are responsible for any balance not paid by your insurance carrier.***

Subscriber's Name: _____ Relationship : _____ Self _____ Spouse _____ Parent _____ Other

Subscriber's Date of Birth : _____ Subscriber's Social Security # (Required) : _____

Address: _____ City: _____ State: _____ Zip Code: _____

Insured's employer: _____

Employer Address: _____ Work Phone: _____

DENTAL INSURANCE:

Name of Carrier: _____ Address: _____

Phone Number: (_____)_____ _____

Group Number: _____ Insured's I.D. # _____

MEDICAL INSURANCE:

Name of Carrier: _____ Address: _____

Phone Number: (_____)_____ _____

Group Number: _____ Insured's I.D. # _____

HEALTH QUESTIONNAIRE

Date: _____ Patient's Name: _____

***** PLEASE ANSWER BY CIRCLING YES (Y) OR NO (N) FOR EACH QUESTION*****

1. Are you currently under a physician's care?..... Y N
   If so, for what? _____

2. Have you had any serious operations or hospitalizations? ..... Y N
   If so, please explain _____

3. Have you ever had IV sedation or general anesthesia? ..... Y N
   Did you have any bad effects? _____

4. DO YOU HAVE OR HAVE YOU EVER HAD:

• Heart murmur? …	Y N	• Stomach problems? …	Y N
• Cardiovascular disease? …	Y N	• Glaucoma? …	Y N
• Lung disease? …	Y N	• Epilepsy? …	Y N
• Neurological disease? …	Y N	• Implants or artificial joints? …	Y N
• Blood disease? …	Y N	• Cancer?…	Y N
• Liver disease? …	Y N	• Radiation? …	Y N
• Kidney disease?…	Y N	• Sinus or nasal problems? …	Y N
• Thyroid disease? …	Y N	• Recurrent infections? ...	Y N
• Diabetes? …	Y N	• Mouth sores? …	Y N
• Arthritis? …	Y N	• Hepatitis? …	Y N
• High blood pressure? …	Y N	• HIV or AIDS? ….	Y N

5. PLEASE LIST ALL CURRENT MEDICATIONS: (include aspirin & all over the counter medication)
   _____
   _____

6. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:

• Local anesthetic? …	Y N	• Aspirin, ibuprofen, etc? …	Y N
• Penicillin or Amoxicillin? ...	Y N	• Codeine? …	Y N
• Other antibiotics? …	Y N	• Latex? …	Y N
• Barbiturates or sedatives? …	Y N	• Any other allergies? _____	

7. Do you drink alcohol? If so, how much per day? _____ ..... Y N
8. Do you smoke? If so, how much per day? _____ # of years? _____ ..... Y N
9. Do you use chewing tobacco? If so, how much? _____ # of years? _____ ..... Y N
10. Do you use marijuana, cocaine, or other recreational drugs? ..... Y N

11. WOMEN ONLY
    - Are you taking birth control pills or hormones? ..... Y N
    - Are you pregnant or any chance you might be pregnant? ..... Y N
    - Are you breast feeding? ..... Y N

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.
(All information provided will be kept confidential.)

_____ _____

Date *Signature of person completing Health Form*

Revised on 02/16/2006