A

PATIENT INFORMATION

Last Name_______________ First Name_______________ MI_______

Nickname_______________ Birthdate _______________ Male Female

Address _______________ City_______________ State_______ Zip_______

Home Phone_______________ Cell Phone_______________ Business Phone_______________

Email_______________ Social Security #_______________

Employer _______________ Occupation_______________ Years Employed_______________

What is your preferred method of contact: Phone Call / Text / Email _______________

FAMILY INFORMATION

Other family members treated in our office_______________

Spouse And/or Other Responsible Billing Party (Please Circle) Relationship to patient_______________

Last Name_______________ First Name_______________ MI_______

Address_______________ City_______________ State_______ Zip_______

Home Phone_______________ Cell Phone_______________ Business Phone_______________

Email_______________ Birthdate _______________ Social Security #_______________

Employer _______________ Occupation_______________ Years Employed_______________

In case of emergency, please list someone other than those above who will know how or where to contact you.

Name_______________ Relationship_______________

Address_______________ Phone Number_______________

INSURANCE

Are you covered by a group or private dental insurance plan? _____Yes _____No If yes, please complete a Signature on File form.

Reason for Visit_______________

____

How did you hear about us or whom may we thank for referring you?_______________

MEDICAL INFORMATION

Physician____City___________________________________Date of Last Visit__________

Dentist____City___________________________________Date of Last Visit__________

Pharmacy____Location____

For Females: Are you pregnant?____

List any medications you are currently taking____

List any allergies to food/medicine/metals____

List any hospitalizations or surgeries____

Have you ever had a serious injury to your head or neck?____

Have you had any injuries to your teeth or jaws? (falls, blows, chips, etc.)____

Are you currently under the care of a physician? If so, for what?____

____

Please check if you have a history of any of the following:

____Asthma / Respiratory problems ____ADD / ADHD ____Behavioral issues

____Bleeding / Blood disorders ____Cancer ____Developmentally Delayed

____Diabetes ____Eating Disorders ____Epilepsy

____Gastric reflux / Stomach disorders ____Heart trouble / Murmurs ____Hepatitis / AIDS

____Kidney / Liver issues ____Latex Allergy ____Seizures / Convulsions

____Other

Additional information you feel may be pertinent to your treatment____

____

____

I acknowledge that I have completed this form, read and answered the questions to the best of my knowledge. I will inform this practice of any changes to this record or my medical/dental status. I understand that if appropriate, credit bureau reports may be obtained.

____ ____________________

Signature Date