Date: _____

Personal Information

Name: _____
Address: _____
City:_____
Telephone: (Home)_____(Work) _____
(Cell) _____ Email:_____
Birth Date: _____Sex: _____Spouse Name: _____
Occupation: _____Referred By: _____

Person Responsible For Account

Name: _____Relationship: _____
Address: _____
City: _____State: _____Zip:_____
Telephone (Home):_____(Work) _____

College Student

Full Time? Yes No
School Name: _____

Dental Insurance Information

Primary Insurance Co: _____
Insurance Co. Address: _____
Employee: _____Relationship: _____DOB: _____
SS#:_____Employer: _____
Policy #: _____

I understand that payment is my obligation regardless of insurance or any other third-party involvement.

Signature: _____Date: _____

Pre-Med

Does your physician require you to be pre-medicated? Yes No
Physicians Name _____Phone _____
Medical Reason _____
Pharmacy _____Pharmacy Phone_____
Please provide a copy of the medical prescription from your doctor**.**

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Patient Name: _____ Initial Date: _____

Updated: _____

Patient Medical History

1. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking

   _____

   _____

   _____

2. Do you use tobacco Yes No
3. Are you **allergic** to or have had any reactions to the following :

Local Anesthetics	Yes	No
Penicillin or any other antibiotics	Yes	No
Sulfa Drugs	Yes	No
Barbiturates	Yes	No
Any Metals (Nickel, Mercury, etc.)	Yes	No
Latex Rubber	Yes	No
Women Only: Are you Pregnant?	Yes	No
Are you taking oral contraceptives?	Yes	No
Are you taking a blood thinner?	Yes	No

4. Have you had or have any of the following:

Heart Valve Replacement	Yes	No	Vascular Graft	Yes	No
High Blood Pressure	Yes	No	Heart Disease	Yes	No
Rheumatic Fever	Yes	No	Cardiac Pacemaker	Yes	No
Heart Murmur	Yes	No	Angina	Yes	No
Fainting/Seizures	Yes	No	Asthma	Yes	No
Stroke	Yes	No	Emphysema	Yes	No
Cancer	Yes	No	Epilepsy/Convulsions	Yes	No
Diabetes	Yes	No	Liver Disease	Yes	No
Kidney Disease	Yes	No	Radiation Therapy	Yes	No
AIDS or HIV	Yes	No	Hepatitis	Yes	No
Joint Replacement	Yes	No	Mitral Valve Prolapse	Yes	No
Hay Fever/Allergies	Yes	No	GURD/Acid Reflex	Yes	No
HPV	Yes	No	Sleep Apnea	Yes	No
Joint Replacement	Yes	No	Other _____		

If you have answered yes to any of the above, please explain.

_____

_____

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Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the dentist to release any information including diagnosis and records rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company pay directly to the dentist. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Signature of patient (or parent/guardian)

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