PATIENT INFORMATION

Name First:________________Last :___________________ Preferred Name________________________________

Birth Date______________ Age_________ Sex M/F SS# ______________________________

Home Phone __________________ Cell____________________ Work___________________ Ext________

Email____

Mailing Address ______________________________________City&State_________________Zip________

Your Employer_______________________________________ Spouse's Name_______________________

Spouses Birth Date ____________ SS#___________________ Employer____________________________

Name of relative not living with you________________________________ phone#_____________________

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

Name of previous dentist____

INSURANCE INFORMATION

Dental Insurance Co.______________________________ ID#________________ Group #_____________

Secondary Insurance_______________________________ ID#________________ Group #_____________

MEDICAL HEALTH HISTORY

Please check any that apply to you.

HIV Positive__
Joint Replacement___
Stroke___
Asthma___
Seizures___
Cancer___
Heart Murmur___
Lungs ___

Diabetes___
Rheumatic Fever___
High Blood Pressure___
Hepatitis___
Kidneys___
Stomach or Intestines___
Tuberculosis___

Liver___
Blood Thinners___
Bleeding Disorder___
Heart Condition___
Drug Abuse___
Phen-Fen___
Headaches___
Pregnant___

Please list all prescriptions or over the counter medicine you are currently taking:

____

____

Please list ANY allergies or sensitivities you may have:

____

Is there anything you would like to change about your smile?:

____

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