PLEASE FILL OUT THIS SIDE ONLY

PATIENT INFORMATION

What can we do for you? ______________________ Date ______________

Patient's Name: ______________________ Sex: M F D.O.B. ____/____/____

Address: ______________________ City: ______________ State: ________

Home Phone: ______________ Work Phone: ______________ E-mail Address: ______________

Employer: ______________ Address: ______________________

Occupation: ______________ Spouse, Parent, Guardian, S.O.: ______________

Who may we thank for referring you to our office? ______________________

Name and address of closest relative not living with you: ______________________

HEALTH HISTORY

Family Physician and Address ______________________ Last Physical Exam ___/___/___

Please write YES for any of the following which you have or have had or place a NO after each condition that does not apply to you:

1. heart problems ______	7. HIV positive ______	13. tuberculosis (TB) ______	19. fever blister ______
2. mitral valve prolapse ______	8. cold sores ______	14. epilepsy/seizures ______	20. stroke ______
3. cardiac pacemaker ______	9. diabetes ______	15. sinus trouble ______	21. thyroid disease ______
4. heart murmur ______	10. high/low bld. pres. ______	16. arthritis ______	22. allergies (medicinal or otherwise) ______
5. rheumatic fever ______	11. liver disease ______	17. cancer treatment ______	
6. med. prosth./joints ______	12. hepatitis ______	18. excessive bleeding ______	

23. Have you been hospitalized or under a physician's care this past year? ______________ Y N

24. Are you on any medication? ______________ Y N

25. Have you had any other serious illnesses? ______________ Y N

26. (Women) Are you pregnant now? (Due Date ____/____/____) Taking Birth Control Pills? ______________ Y N

27. Do you prefer local anesthesia (novacaine) when you have dental restoration (fillings) done? ______________ Y N

Comments: (Item #) ______________________

____

______________________ Blood Pressure ____/____

CONSENT FOR TREATMENT:

The undersigned hereby authorized Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropraite by Doctor to make a thorough diagnosis of the patient's debtal needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) ______________ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthesia agents embodies a certain risk.

Patient ______________________ Date ____/____/____ Witness ______________

Parent or Responsible Party ______________________ Relation F M S S.O. Other ______________

Hobbies/Interests: TV ______ Hours/day ______________________

FINANCIAL INFORMATION

Full payment is expected for each visit. Please circle how you prefer to pay: cash check credit card

If you have dental insurance, please fill in the information below so we can complete and mail the insurance claims for you.

Primary Dental Insurance

Insurance Co. Name: ______________

Insurance Co. Address: ______________

Insurance Co. Phone #: ______________

Group # (Plan, Location or Policy #): ______________

Insured's Name: ______________ Relation: ______________

Insured's Birthday: ____/____/____ Insured's S.S.#: ______________

Insured's Employer: ______________

Secondary Dental Insurance

Insurance Co. Name: ______________

Insurance Co. Address: ______________

Insurance Co. Phone #: ______________

Group # (Plan, Location or Policy #): ______________

Insured's Name: ______________ Relation: ______________

Insured's Birthday: ____/____/____ Insured's S.S.#:

Insured's Employer: ______________