Patient Information (Please Print)

Patients Name	Marital Status S M W D SEP	Date of Birth		Age	Social Security No.
Street Address Permanent Temporary	City and State			Zip Code	Home Phone No.
Patient's or Parent's Employer	Occupation (Indicate If A Student)	How Long Employed			Bus. Phone No.
Employer's Street Address	City and State			Zip Code	Extension
Spouce or Parent's Name	Number of Children and Ages				Cell Phone No.
Person Responsible for Payment	Street Address, City, State & Zip Code				Pager No.
Spouce's Employer	Spouse's or Parents Social Security No.				
Whom May We Thank For Referring You?	Your Email Address				

Dental Insurance Information

Primary Insurance Company	Address and Phone #		Group Number
Insured's Name	Relationship To You	Insured's Social Security No. & Date of Birth	
Secondary Insurance Company	Address and Phone #		Group Number
Insured's Name	Relationship To You	Insured's Social Security No. & Date of Birth	

Medical History

Physician's Name _____ Date of Last Physical Exam _____

Previous Dentist Name _____ Date of Last Thorough Dental Exam _____

Answer All Questions (Check "Yes" or "No")

Y___	N___	Angina Pectoris	Y___	N___	Circulatory Problems	Y___	N___	Hepatitis
Y___	N___	Heart Murmur	Y___	N___	Stroke	Y___	N___	Rheumatic Fever
Y___	N___	Heart Problems	Y___	N___	Sinus Problems	Y___	N___	AIDS
Y___	N___	High Blood Pressure/Low	Y___	N___	Asthma	Y___	N___	Sexually Transmitted Disease
Y___	N___	Mitrovalve Prolapse	Y___	N___	Diabetes	Y___	N___	Kidney Disease
Y___	N___	Nervous Problems	Y___	N___	Jaundice	Y___	N___	Artificial Valves
Y___	N___	Psychiatric Treatment	Y___	N___	Scarlet Fever	Y___	N___	Artificial Bones/Joints
Y___	N___	Cancer/Chemotherapy	Y___	N___	Tonsilitis	Y___	N___	Pacemaker
Y___	N___	Epilepsy	Y___	N___	Tuberculosis	Y___	N___	Do you use tobacco products?
Y___	N___	Mononucleosis	Y___	N___	Ulcer	If Yes, what kind and how much?		
Y___	N___	Arthritis	Y___	N___	Excessive Bleeding			
			Y___	N___	Osteoporosis			

Are you alergic to any of the following

Y___	N___	Penicillin	Y___	N___	Sulfa Drugs	
Y___	N___	Asprin	Y___	N___	Codine or other narcotics	List any allergies or drug reactions:
Y___	N___	Erthromycin	Y___	N___	Latex	
Y___	N___	Tetracycline	Y___	N___	Anesthetics	
			Y___	N___	Jewelry, metal	

Are your pregnant or nursing? _____ Have you been hospitalized or had surgery in the last 12 months? _____

Have you ever been told that you should pre medicate for medical or dental appointments? _____

Are you taking any medications? Y ___ N ___ If yes, See Backside of Form

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees regardless of insurance coverage. The patient agrees that in the event of any default in payment of account, patient will be liable for attorney's fees and cost of collection which includes a 15% serice fee.

Signature of patient (or parent if minor) Date

Office Use Only

I Have reviewed the Medical/Dental Information above with the patient named herein.

(Signature) (Date)

List Of Medication

Name of Medication	Dosage	Times per Day