PATIENT INFORMATION

FIRST NAME:	LAST NAME:	MI:
DATE OF BIRTH:	SEX: MALE FEMALE	

ADDRESS: ____
STREET CITY STATE ZIP CODE

HOME # CELL # EMAIL ADDRESS

CHECK APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

PATIENT/GUARDIAN'S EMPLOYER:	WORK PHONE:

BUSINESS
ADDRESS: ____
STREET CITY STATE ZIP CODE

SPOUSE OR PARENT/GUARDIAN NAME	EMPLOYER	WORK PHONE
IF PATIENT IS A STUDENT, NAME OF SCHOOL	CITY	STATE/PROV.

WHOM MAY WE THANK FOR REFERRING YOU?

EMERGENCY CONTACT	PHONE

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT	**RELATIONSHIP TO PATIENT:**
ADDRESS	HOME PHONE
EMAIL	CELL PHONE
DRIVER'S LICENSE	
Birth Date	Financial Institution
Employer	Work Phone

Is This Person Currently a Patient in our office? YES NO

Insurance Information

NAME OF INSURED	**RELATIONSHIP TO PATIENT:**	
BIRTH DATE	SSN	WORK PHONE

EMPLOYER
ADDRESS: ____
STREET CITY STATE ZIP CODE

Primary Health Insurance Company Name and Address:

____
Insurance Company Name Street City State Zip Code

ID#:	Group#	Effective Date:
AMOUNT OF DEDUCTIBLE?	HOW MUCH HAVE YOU USED?	MAX ANNUAL BENEFITS

Secondary Health Insurance Information

NAME OF INSURED	**RELATIONSHIP TO PATIENT:**	
BIRTH DATE	SSN	WORK PHONE

EMPLOYER
ADDRESS: ____
STREET CITY STATE ZIP CODE

Primary Health Insurance Company Name and Address:

____
Insurance Company Name Street City State Zip Code

ID#:	Group#	Effective Date:
AMOUNT OF DEDUCTIBLE?	HOW MUCH HAVE YOU USED?	MAX ANNUAL BENEFITS

X____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

PATIENT NAME	______________________	**TODAY'S DATE**	______________
HOME ADDRESS	______________________	**DATE OF BIRTH**	______________
	______________________	**HOME PHONE**	______________
EMAIL	______________________	**CELL PHONE**	______________
BUSINESS ADDRESS	______________________	**BUSINESS PHONE**	______________
	______________________	**SSN/SIN**	______________

PATIET MEDICAL HISTORY

PHYSICIAN	PHONE:	DATE OF LAST EXAM

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?		
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?		
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?		

IF YES, LIST MEDICATION(S) ______________________________

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	YES	NO
4. HAVE YOU EVER TAKEN FEN-PHEN/REDUX?		
5. DO YOU USE TOBACCO		
6. DO YOU USE ALCOHOL OR OTHER DRUGS?		
7. ARE YOU WEARING CONTACT LENSES?		

8. ARE YOU ALLERGIC TO OR HAVE HAD ANY REACTIONS TO THE FOLLOWING?

YES	NO		YES	NO	
		LOCAL ANESTHETICS (IE NOVOCAINE)			BARBITUATES
		ANTIBIOTICS			SEDATIVES
		ASPIRIN			SULFA DRUGS
		IODINE			OTHER

	YES	**NO**
9. DO YOU HAVE PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN WEEKS?		
10. WOMEN ONLY:		
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?		
B) ARE YOU NURSING?		
C) ARE YOU TAKING BIRTH CONTROL?		

11. DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
		HIGH BLOOD PRESSURE			HEART DISEASE			CHEST PAINS
		HEART ATTACK			CARDIAC PACEMAKER			EASILY WINDED
		RHEMATIC FEVER			HEART MURMUR			STROKE
		SWOLLEN ANKLES			ANGINA			HAY FEVER/ALLERGIES
		FAINTING/SEIZURES			FREQUENTLY TIRED			TUBERCULOSIS
		ASTHMA			ANEMIA			RADIATION THERAPY
		LOW BLOOD PRESSURE			EMPHYSEMA			GLAUCOMA
		EPILEPSY/ CONVULTIONS			CANCER			RECENT WEIGHT LOSS
		LEUKEMIA			ARTHRITIS			LIVER DISEASE
		DIABETES			JOINT REPLACEMENT OR IMPLANT			HEART TROUBLE
		KIDNEY DISEASES			HEPATITIS/JAUNDICE			RESPIRATORY PROBLEMS
		AIDS OR HIV INFECTION			SEXUALLY TRANSMITTED DISEASE			OTHER
		THYROID PROBLEM			STOMACH TROUBLES/ULCERS			______________________

PATIET DENTAL HISTORY

	YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?		
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS OR FOOD?		
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?		
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?		
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?		
6. HAVE YOU HAD ANY HEAD, NECK, OR JAW INJURIES?		
7. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
A) CLICKING?		
B) PAIN (JOINT, EAR, SIDE OF FACE)?		
C) DIFFICULTY IN OPENING OR CLOSING?		
D) DIFFICULTY IN CHEWING?		

	YES	NO
8. DO YOU HAVE FREQUENT HEADACHES?		
9. DO YOU CLENCH OR GRIND YOUR TEETH?		
10. DO YOU BITE YOUR LIPS OF CHEEKS FREQUENTLY?		
11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?		
12. HAVE YOU HAD ANY ORTHODONTIC WORK?		
13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?		
14. HAVE YOU EVER HAD ISTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?		
15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS?		

COMMENTS:

I CERTIFY THAT I HAVE READ AND UNDERSTAD THE ABOVE INFORMATION, TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ASWERED. I UNDERSTAD THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

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PATIENT, PARENT OR GUARDIAN SIGANATURE DATE