PATIENT INFORMATION (Please Print)

NAME: _____
FIRST: M.I.: LAST:

NICKNAME: _____ DATE OF BIRTH: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL/WORK PHONE: _____

E-MAIL: _____

SPOUSE'S/PARTNER'S NAME: _____

PATIENT EMPLOYED BY: _____

PATIENT PRESENT POSITION: _____

WHO MAY WE CONTACT IN CASE OF AN EMERGENCY? _____

NAME: _____ PHONE: _____

WHO REFERRED YOU TO OUR OFFICE? _____

DO YOU HAVE DENTAL INSURANCE? _____

NAME OF INSURANCE COMPANY: _____

SOC. SECURITY # OF PATIENT: _____

SOC. SECURITY # OF POLICY HOLDER: _____

PAYING BY: CASH CREDIT CARD CHECK CARECREDIT

I understand and agree that (regardless of insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any change in my health status or the above information.

PATIENT SIGNATURE: _____ DATE: _____

PARENT SIGNATURE (if minor): _____ DATE: _____

MEDICAL HISTORY

ARE YOU PRESENTLY UNDER CARE OF A PHYSICIAN? _____

IF SO, PLEASE GIVE REASON(S) FOR TREATMENT: _____

_____

_____

PHYSICIAN'S NAME: _____

PHYSICIAN'S PHONE: _____

HAVE YOU BEEN HOSPITALIZED FOR ANY CONDITION? _____

IF SO, PLEASE GIVE REASON: _____

_____

ARE YOU TAKING ANY KIND OF MEDICATION (PRESCRIBED OR OVER THE COUNTER) OR DRUG(S) AT THIS TIME? _____

IF SO, PLEASE GIVE NAME(S) OF THE MEDICATIONS AND REASON(S) FOR TAKING THEM: _____

_____

_____

ARE YOU ALLERGIC TO PENICILLIN/LATEX/OR ANY OTHER AGENTS? _____

_____

PLEASE CIRCLE YES OR NO TO ANY ILLNESSES OR MED'S YOU HAVE EVER HAD OR TAKEN

AIDS	Y-N	DRUG/NARCOTIC DEPENDENCY	Y-N	PROLONGED BLEEDING	Y-N
HIV	Y-N	EPILEPSY	Y-N	PSYCHIATRIC CARE/ MENTAL ILLNESS	Y-N
ALCOHOLISM	Y-N	GLAUCOMA	Y-N	RESPIRATORY	Y-N
ANEMIA	Y-N	HEAD OR NECK INJURIES	Y-N	RHEUMATIC FEVER	Y-N
ARTIFICIAL JOINT	Y-N	HEART PROBLEMS	Y-N	SINUS TROUBLE	Y-N
ASTHMA	Y-N	HERPES OR FEVER BLISTERS	Y-N	STROKE	Y-N
HIGH OR LOW BP	Y-N	HEPATITIS A (INFECTIOUS)	Y-N	TUBERCULOSIS	Y-N
BLOOD THINNERS	Y-N	HEPATITIS B (SERUM)	Y-N	ULCERS	Y-N
CANCER	Y-N	KIDNEY OR LIVER PROBLEMS	Y-N	VENEREAL DISEASE	Y-N
DIABETES	Y-N	MIGRAINES	Y-N	OTHER	Y-N
DIET PILLS	Y-N	PACE MAKER	Y-N		

ARE YOU PREGNANT? HOW FAR ALONG? _____

HAVE YOU HAD PREVIOUS ENDODONTIC (ROOT CANAL) TREATMENT? _____

SIGNATURE: _____ DATE: _____