Patient Information

Name _____
LAST FIRST MIDDLE INTIAL PREFERRED NAME

Address _____
STREET

_____
CITY STATE ZIP

Employer _____

Birth Date _____ ☐ Married ☐ Single ☐ Other

Height _____ Weight _____ ☐ Male ☐ Female

Phone: Home (____) _____ Social Security # _____
Work (____) _____
Cell (____) _____ Email: _____

Emergency Contact: Name _____ Phone (____) _____

How did you hear about us? _____

Insurance (If you have your insurance card, you do not need to fill this portion out)

Primary Dental Carrier

Subscriber Name: _____ Subscriber ID # _____DOB _____
Employer _____ Insurance Co. _____
Insurance Co. Phone # _____ Group # _____
Relation to patient

Secondary Dental Carrier

Subscriber Name: _____ Subscriber ID # _____DOB _____
Employer _____ Insurance Co. _____
Insurance Co. Phone # _____ Group # _____
Relation to patient

The information on this page is correct to the best of my knowledge. (Sign and date)

Signature _____Date_____

If patient is under 18

Responsible party _____ Relation to Patient _____

Address _____
STREET CITY STATE ZIP

Telephone (____) _____

Other Information

Physician's Name _____ Physician's Phone # _____
Have you had a serious illness or operation? Y____ N ____
If yes, please describe _____
Are you currently under a physician's care? Y____ N ____
If yes, please describe _____

Medical History and Information

Conditions

- Abnormal bleeding
- Alcohol abuse
- Allergies
- Anemia
- Angina Pectoris
- Arthritis
- Artificial heart valve
- Asthma
- Bisphosphates
  - Oral
  - IV
- Blood transfusion
- Cancer
- Chemotherapy
- Colitis
- Congenital heart defect
- Diabetes
- Difficulty breathing
- Drug abuse
- Emphysema
- Epilepsy
- Facial surgery
- Fainting spells
- Fever blisters
- Frequent headaches
- Glaucoma
- HIV+ Aids
- Heart attack
- Joint replacement
- Heart murmur
- Heart surgery
- Hemophilia
- Hepatitis A
- Hepatitis B
- Hepatitis C
- High blood pressure
- Kidney problems
- Liver disease
- Low blood pressure
- Mitral valve prolapse
- Pace maker
- Psychiatric problems
- Radiation therapy
- Rheumatic fever
- Seizures
- Shingles
- Sickle cell disease
- Sinus problems
- Stroke
- Thyroid problems
- Tuberculosis
- Ulcer

Allergies

- Aspirin
- Codeine
- Dental anesthetics
- Erythromycin
- Latex
- Metals
- Penicillin
- Sulpha
- Other

_____

Check yes if you

- Smoke or use Tobacco
- Are pregnant
  # of weeks
- Are nursing

Please list any medication you are currently taking:

_____
_____

Treatment Authorization Form

The information on this page is correct to the best of my knowledge. I authorize and give consent to perform dental services agreed between doctor and patient and/ or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

_____ _____
Patient's Signature Date

If patient is a child or requires a guardian:

_____ _____
Parent/ guardian's Signature Date