



New Patient Information

Name: _____ Date _____
 First Last M
SS# _____ Birthday _____ Married Single Male Female
Address _____
 Street Apt# City State Zip
Home Phone _____ Cell _____ Work _____
Email: _____ Place of Employment _____
Spouse Name _____ Birthday _____ Spouse Employer _____
Cell Phone _____ Work Phone _____ SS# _____

Minors Only

Resides with: Both Parents Mother Father Other _____

FATHER _____ Father's Birthday _____ SS# _____

Address (If different) _____ Cell Phone: _____

Place of Employment _____ Work Phone: _____

MOTHER _____ Mother's Birthday _____ SS# _____

Address (If different) _____ Cell Phone: _____

Place of Employment _____ Work Phone: _____

Other _____ Birthday _____ SS# _____

Address (If different) _____ Cell Phone: _____

Place of Employment _____ Relationship to Minor _____ Work Phone: _____

Dental Insurance

Primary Policy Holder: _____ Name of Insurance Company: _____

Secondary Policy Holder: _____ Name of Insurance Company: _____

Alternate Contact

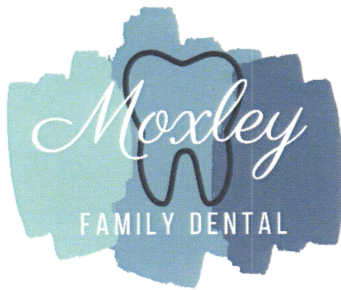
OUTSIDE OF FAMILY HOUSEHOLD

Name: _____ Relationship _____

Home Phone _____ Cell _____ Work _____

I hereby authorize directly to the Dental Office of the group insurance benefits otherwise payable to me, I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. The information on this page and dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

X _____ Date _____
Patient or Responsible Party Signature



Dental History

Patient Name: _____
 Reason for Today's Visit _____ Date of last dental care _____
 Former Dentist _____ Date of last dental X-rays _____
 Address _____
 Occupation/Employer: _____
 How often do you floss? _____ How often do you brush? _____

Medical History

Physician's Name _____ Date of Last visit _____

Have you ever taken any of the group of drugs collectively referred to as Bisphosphonates? These include Zometa, Fosamax, Actonel, Boniva, Reclast, Aredia, Phenphen, Redux Etc. _____

Have you had any serious illness or operations? _____ If yes, Describe _____

Have you ever had a blood transfusion? _____ If yes, give approximate date _____

(Women) Are you Pregnant? Yes or No Nursing? Yes or No Taking birth control pills? Yes or No

Check if you have or have had any of the following:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Anemia
<input type="checkbox"/> Arthritis, Rheumatism
<input type="checkbox"/> Artificial Heart Valve
<input type="checkbox"/> Artificial Joints
<input type="checkbox"/> Asthma
<input type="checkbox"/> Blood Disease
<input type="checkbox"/> Cancer
<input type="checkbox"/> Chemical Dependency
<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Cortisone Treatment
<input type="checkbox"/> Cough, Persistent
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Fainting
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Headaches
<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Heart Problems
<input type="checkbox"/> Hemophilia | <input type="checkbox"/> Hepatitis
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Jaw Pain
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Stroke
<input type="checkbox"/> Swelling of Feet or Ankles
<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Tobacco Habit
<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Ulcer
<input type="checkbox"/> Venereal Disease |
|--|---|---|---|

Medications

Allergies

List Medications you are currently taking: _____

Pharmacy Name: _____
 Phone (____) _____

- | | |
|---|---|
| <input type="checkbox"/> Aspirin
<input type="checkbox"/> Barbiturates (Sleeping Pills)
<input type="checkbox"/> Codeine
<input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Penicillin
<input type="checkbox"/> Sulfa
<input type="checkbox"/> Latex
<input type="checkbox"/> Other |
|---|---|

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in completion of this form.

Date _____ Signature _____