PATIENT INFORMATION:

NAME/FIRST | MIDDLE INITIAL | LAST | BIRTHDATE | PHONE NUMBER

STREET ADDRESS | CITY | STATE | ZIP

SOCIAL SECURITY # | NAME OF DENTIST | HOW LONG HAVE YOU BEEN HIS/HER PATIENT?

EMPLOYER | OCCUPATION | WORK OR CELL PHONE

SPOUSE OR PARENT NAME | BIRTHDATE | SOCIAL SECURITY #

SPOUSE/PARENT EMPLOYER | OCCUPATION

DENTAL INSURANCE

PRIMARY INSURANCE CO _____ SECONDARY INSURANCE CO _____

EMPLOYER _____ EMPLOYER _____

INSURED'S NAME _____ INSURED'S NAME _____

I.D. # _____ GROUP # _____ I.D. # _____ GROUP # _____

PATIENT HEALTH HISTORY

Please indicate if you have had….

	Yes	No
DIABETES	☐	☐
EXCESSIVE BLEEDING	☐	☐
RESPIRATORY PROBLEMS	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐

	Yes	No
LIVER PROBLEMS	☐	☐
KIDNEY PROBLEMS	☐	☐
ALLERGIES: Penicillin	☐	☐
Aspirin	☐	☐

Other medication allergies _____

	Yes	No
HEART TROUBLE	☐	☐

Please specify with dates _____ _____ _____

	Yes	No
INFECTION HEPATITIS	☐	☐

When _____ _____ _____

	Yes	No
CAN YOU USE LOCAL DENTAL ANESTHETIC	☐	☐

NAME OF MEDICAL DOCTOR _____

Have you been treated by your physician in the last 60 days: Yes ☐ No ☐

If so, for….(please explain) _____

LIST OF MEDICATIONS AND REASON FOR TAKING:

_____

_____

_____

DATE _____ SIGNATURE OF PATIENT OR LEGAL GUARDIAN _____