



PATIENT INFORMATION

Today's Date _____

Patient's Name _____ Social Security # _____

Street Address _____ Home phone _____

City, State, Zip _____ Cell phone _____

E-mail address _____ Male Female

Marital Status _____ Birth Date _____

Employer _____ Occupation _____

Work Address _____ Work phone _____

City, State, Zip _____

Spouse / Parent _____ Social Security # _____

Street Address _____ Home phone _____

City, State, Zip _____ Cell phone _____

E-mail address _____ Birth Date _____

Employer _____ Occupation _____

Work Address _____ Work phone _____

City, State, Zip _____

Nearest Relative _____ Home phone _____

Street Address _____ Cell phone _____

City, State, Zip _____

Person who is responsible for the account _____

Street Address _____ Home Phone _____

City, State, Zip _____ Cell phone _____

Former dentist _____ Do you have dental insurance? yes no

Date of last dental visit _____ Company _____

I was referred by _____ Group# _____

Main Dental Complaint _____

Are you interested in having [A] all dental work done or [B] just your immediate problem?

Preferred method of payment

Cash Check MC Visa AmEx Disc

A service charge of 1½% (minimum \$1.00) may be charged on accounts over 30 days past due.

PATIENT MEDICAL PROFILE

Physician's Name _____ Street Address _____

Physician's Phone _____ City, State, Zip _____

Date of last medical exam _____

Are you sensitive or allergic to any drugs or medicine? yes no

If yes, please list: _____

Please list current medications: _____

Please describe any unusual effect from any previous dental treatment: _____

Please describe all conditions treated by a physician within the past year: _____

If patient now has or ever had the following please check yes or no.

Asthma . . . yes <input type="checkbox"/> no <input type="checkbox"/>	Excessive bleeding . . yes <input type="checkbox"/> no <input type="checkbox"/>	Heart trouble . . . yes <input type="checkbox"/> no <input type="checkbox"/>
Bronchitis . . .yes <input type="checkbox"/> no <input type="checkbox"/>	Rheumatic fever . . . yes <input type="checkbox"/> no <input type="checkbox"/>	Stomach trouble . yes <input type="checkbox"/> no <input type="checkbox"/>
Diabetes . . .yes <input type="checkbox"/> no <input type="checkbox"/>	HIV+ virus (Aids) . . yes <input type="checkbox"/> no <input type="checkbox"/>	Kidney trouble . . yes <input type="checkbox"/> no <input type="checkbox"/>
Hip surgery .yes <input type="checkbox"/> no <input type="checkbox"/>	Joint replacement . . yes <input type="checkbox"/> no <input type="checkbox"/>	Scarlet fever yes <input type="checkbox"/> no <input type="checkbox"/>
Allergies . . .yes <input type="checkbox"/> no <input type="checkbox"/>	Mitral valve prolapse yes <input type="checkbox"/> no <input type="checkbox"/>	Tuberculosis yes <input type="checkbox"/> no <input type="checkbox"/>
Hepatitis . . .yes <input type="checkbox"/> no <input type="checkbox"/>	High blood pressure yes <input type="checkbox"/> no <input type="checkbox"/>	Orthodontics . . . yes <input type="checkbox"/> no <input type="checkbox"/>
Faint easily . .yes <input type="checkbox"/> no <input type="checkbox"/>	Periodontal surgery yes <input type="checkbox"/> no <input type="checkbox"/>	Pyorrhea or bleeding of the gums yes <input type="checkbox"/> no <input type="checkbox"/>
Anemiayes <input type="checkbox"/> no <input type="checkbox"/>	Venereal disease . . . yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/>
Convulsions.yes <input type="checkbox"/> no <input type="checkbox"/>	Are you Pregnant? . . yes <input type="checkbox"/> no <input type="checkbox"/>	Other _____

Please describe any current medical treatment, impending operations or any other information that may possible affect your dental treatment:

What is your reaction to having dental work done?

Dread it Worry about it Don't mind it

For your dental treatment, would you prefer:

Local anesthetic (injections) Nitrous oxide (gas) Both Nothing

The above information is true and correct to my knowledge. I understand that I am responsible for payment of my account and all court costs and attorney's fees incurred if necessary for collection, regardless of insurance coverage.

Signature _____ Date _____

We always welcome new patients and we will be happy to serve your colleagues, family and friends!