CONFIDENTIAL – MEDICAL AND PERSONAL HISTORY

Patient's Name _____ **Preferred Name:** _____ **Sex:** M F

Age: _____ **Birth Date:** _____ **SS#**_____ **Address**:_____

Cell Phone: _____ **Home/Other:** _____ **City, State:** _____ **Zip** _____

Work Phone: _____ (please include area codes) **Email:** _____

Preferred method of contact: Cell / Work / Email / Home or Other **Dentist:** _____

Person Financially Responsible (if different than above) MUST BE THE PERSON SIGNING AT BOTTOM:

Name _____ **Birth Date**: _____ **Address** _____

Cell Phone: _____ **Other Phone:** _____ **City/State** _____ **Zip** _____

DENTAL INSURANCE INFORMATION:

Primary Insurance

Name of Dental Insurance Co.: _____

Name of Insured (Policy Holder/Subscriber):_____ **Employer of Policy Subscriber:** _____

Policy Subscriber SS or ID #: _____ **Policy Subscriber Birth Date:** _____

Secondary Insurance (If Applicable)

Name of Dental Insurance Co.: _____

Name of Insured (Policy Holder/Subscriber):_____ **Employer of Policy Subscriber:** _____

Policy Subscriber SS or ID #: _____ **Policy Subscriber Birth Date:** _____

HEALTH HISTORY

1. Circle any of the following which you have had or have at present:

Alcoholism/Addiction	Heart Attack/Chest Pains	Lung Disease/Asthma	Sinus Problems/Infection
Arthritis	Heart Stents or Pacemaker	Nerve/Neural	Smoke/Tobacco
Blood Thinner/ Disorder	Heart Trouble – Other	Organ Transplant	Stroke
Cancer (past or present)	Heart Valve Replacement	Osteoporosis/Bone Disease	Thyroid/Hormonal
Chemotherapy	Hepatitis/Liver Disease	Pain Disorder	TMJ/Jaw
Diabetes	Herpes or Cold Sores	Periodontal Disease	Tooth Grinding/Clenching
Dialysis/Kidney Disease	High Blood Pressure	Pregnant/Nursing **(Current only)**	Trigeminal Neuralgia
Fainting/Hypoglycemia	HIV/AIDS	Prosthetic Implant	Tuberculosis
Fibromyalgia	Immune Disease	Psychiatric Care	Ulcer/Digestive
Glaucoma/Visual	Infectious Disease	Radiation (Past or present)	Other:_____
Headaches/Migraines	Joint Replacement	Seizures/Epilepsy	_____

2. Are you allergic to Latex or made sick by any medication (penicillin, aspirin, codeine, ibuprofen, etc.)? ……..Yes No
   If yes, what? _____
3. Have you ever had a reaction to an anesthetic, injection ("Novocain") at the dentist? ……..Yes No
4. Please list ALL medications you are taking (including aspirin, birth control pills, etc.) _____
   _____

Family Physician _____

Financial Responsibility – PERSON RESPONSIBLE FOR FINANCIAL MUST SIGN!

I understand that I am financially responsible for all charges for services rendered to me, including the balance after payment of possible insurance benefits. I agree to pay for all cost involved in pursuing collection of the balance due including court cost, attorney fees, and collection fees, if necessary. I authorize the release of any medical information necessary to process the claim to my insurance carrier. I understand I will need to contact my regular dentist promptly, after completion of treatment, for the permanent (outside) restoration (filling, inlay, crown, etc.). I have answered these questions to the best of my knowledge.

(X) _____
Patient's Signature

(X) _____
Parent's Signature (if under 18)