Confidential Patient Information *(Please Print Legibly)*

PERSONAL INFORMATION

Date: _____

Name: _____ I liked to be called _____

Address:_____ City: _____

State: _____ Zip: _____Telephone: (Home) _____ (Work) _____

(Cell) _____ E-mail _____

Birth date: _____Age:_____ SS #: _____Sex: _____ Marital Status: _____

Spouses Name: _____ REFERRED BY:_____

Employer:_____ _____ Previous Dentists names:_____

Last seen by dentist?_____

Contact person in the event of an emergency _____ Phone_____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relationship: _____ SS #: _____

Address:_____ Birth date:_____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work) _____

DENTAL INSURANCE INFORMATION

Primary Insurance Co: _____

Insurance Co. Address: _____

Employee: _____ Relationship: _____ Date of Birth _____

S.S. #: _____ Employer: _____

Id # _____ Policy #: _____ Group #_____

Secondary Insurance Co: _____

Insurance Co. Address: _____

Employee: _____ Relationship: _____ Date of Birth _____

S.S. #: _____ Employer: _____

Id# _____ Policy #: _____ Group # _____

I understand that payment is my obligation regardless of insurance or any other third-party involvement.

SIGNATURE: _____ DATE:_____

PATIENT REGISTRATION INFORMATION

Patient Name: _____ Date of Birth_____

Update: _____ Note Change:_____ Int:__
Update: _____ Note Change:_____ Int:__
Update: _____ Note Change:_____ Int:__
Update: _____ Note Change:_____ Int:__
Update: _____ Note Change:_____ Int:__
Update: _____ Note Change:_____ Int:__
Update: _____ Note Change:_____ Int:__
Update: _____ Note Change:_____ Int:__
Update: _____ Note Change:_____ Int:__

HEALTH INFORMATION

Personal Physician Name:_____

Yes No

1. Have you been hospitalized within the past two years? For what? _____
2. Are you currently being treated by a physician? For what?_____
3. Are you currently taking any medicines or drugs? Please List: _____

   _____
4. Have you ever taken **bisphosphonate** drugs (Fosamax, Actonel, Boniva, Aredia, Zometa, or other)?
5. Have you ever received counseling for excessive use of Alcohol and/or prescription drugs?
6. Are you allergic to any drugs? What? _____
7. Are you allergic to any metals? What? _____
8. Do you bleed excessively upon injury?
9. Are you pregnant?
10. Do you or have you used any form of tobacco products?

Circle any of the following conditions that you have had.

A. AIDS/HIV Positive	H. *Infectious Endocarditis*	O. Stroke	V. Chronic Cough
B. Hepatitis	I. Heart Pacemaker	P. Drug Addiction	W. Emphysema
C. Tuberculosis	J. Heart Disease or Attack	Q. Diabetes	X. Sinus Trouble
D. *Heart Murmur*	K. Angina Pectoris	R. Cancer	Y. Bruise Easily
E. *Artificial Heart Valve*	L. High Blood Pressure	S. Tumor	Z. Cold Sores/Fever Blisters
F. *Artificial Joints*	M. Congenital Heart Disease	T. Chemotherapy	1. Allergy to Latex
G. *Heart Shunt/Conduit*	N. Heart Surgery	U. Asthma	2. Other Diseases*

* If you circled 2 describe condition:_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Signature: _____ Review: _____ Date: _____