Name:_____ Gender:____M_____F

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email Address:_____

Home Address:_____City:_____ Zip Code:_____

Drivers License Number:_____ State:_____ Expiration Date:_____

Social Security #:_____ Date of Birth:_____

Primary Care Physician:_____Phone:_____

Previous Dentist:_____Phone:_____

Approximate date of your last dental exam:_____

Whom may we contact in case of an emergency?_____ Phone:_____

Whom may we thank for referring you to our office?_____

Who is responsible for this bill?_____

Employer Information:

Employer Name and Address:_____

Employer Phone:_____

Spouse's Name:_____Phone:_____

Social Security #_____ Date of Birth:_____

Insurance Information

Name of Insured:_____ Relationship to Patient:_____

Birthdate:_____ Social Security Number:_____

Name of Employer:_____ Office Phone:_____

Insurance Company:_____Group #_____

Employer/ID#_____

Insurance Company Address:_____ City/State:_____ Zip:_____

Do you have Secondary Insurance? _____Yes _____ No

Name of Insured:_____ Relationship to Patient:_____

Insurance Company:_____ Group:_____ Employer/ID _____

If this claim is accident related, please provide details of the accident:_____

Are you covered under an employer or union policy?

Yes_____ No_____

Have you ever served in the military?

Yes_____ No_____

Are you covered under any other healthcare plan?

Yes_____ No_____

Medical History: Do you have any of the following (Please circle)

AIDS	Cortisone Treatments	Psychiatric Problems
Anemia	Dementia	Psychiatric Treatments
Alzheimers	Diabetes	Radiation Treatment
Arthritis/Rheumatism	Epilepsy	Respiratory Disease
Artificial Heart Valve	Headaches	Rheumatic Fever
Artificial Joints	Heart Attack	Shortness of Breath
Asthma	Heart Murmur	Skin Rash
Back Problems	Hemophilia	Sinus Problems
Bleeding Abnormalities	Hepatitis	Stroke
Blood Disease	Herpes	Thyroid Problems
Cancer	High Blood Pressure	Tobacco Habit
Chemical Dependency	HIV	Positive Tuberculosis
Chemotherapy	Kidney Disease	Other:_____
Circulatory problems	Liver Disease	_____
Cold Sores	Mitral Valve Prolapse	_____
Congenital Heart Lesions	Pacemaker	_____

Are there any other health conditions you may not have listed?
If so, please explain:_____

Please list all Allergies:_____

Please list all medications you are taking?

_____

_____

Date of last dental exam? _____ Reason for today's visit? _____

WOMEN ONLY:
Are you pregnant?____Yes _____No Are you nursing?____ Had an exposure to HPV?____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or in the above information. **THIS INFORMATION WILL BE KEPT CONFIDENTIAL**

_____ _____

Signature Date