PATIENT HISTORY

Patient Name:_____ Date:_____
please print

Date of Birth:_____ SS #:_____ Referring Dentist:_____

Address:_____ City:_____ State:_____ Zip:_____

Billing Address (if different):_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell:_____ E-Mail:_____

Employer/Occupation:_____ Business Phone:_____

Emergency Contact:_____ Relationship:_____ Cell Phone:_____

Primary Physician:_____ Phone #:_____ Last Visit:_____

DO YOU HAVE OR HAVE YOU EVER HAD:

		YES	NO			YES	NO
1.	ANEMIA	___	___	16.	EMPHYSEMA	___	___
2.	DIABETES	___	___	17.	MALIGNANCY	___	___
3.	ASTHMA	___	___		HAVE YOU BEEN TREATED		
4.	HEART TROUBLE	___	___		FOR ANY CANCER	___	___
5.	ALCOHOLISM	___	___	18.	ALLERGIC TO LOCAL		
6.	HEART MURMER	___	___		ANESTHETIC (Novocain)	___	___
	VALVE REPLACEMENT	___	___	19.	ALLERGIC TO ANTIBIOTICS	___	___
	HEART SURGERY	___	___		Please list:_____		
7.	HIGH BLOOD PRESSURE	___	___		_____		
8.	LOW BLOOD PRESSURE	___	___		_____		
9.	BLEEDING PROBLEM	___	___	20.	TAKE DAILY MEDICATION	___	___
10.	KIDNEY DISEASE	___	___		Please list:_____		
11.	DRUG DEPENDENCY	___	___		_____		
12.	JOINT REPLACEMENT	___	___		_____		
	TRANSPLANT SURGERY	___	___		_____		
13.	HEPATITIS	___	___	21.	DO YOU SMOKE	___	___
14.	AIDS	___	___	22.	IF FEMALE ARE YOU PREGNANT	___	___
15.	HIV +	___	___		DO YOU TAKE BIRTH CONTROL PILLS	___	___

REFER TO ABOVE NUMBERED "YES" RESPONSES AND BRIEFLY EXPLAIN BELOW. PLEASE LIST ANY CONDITIONS NOT LISTED ABOVE:_____

_____

_____

_____

Over Please……..

PRIMARY DENTAL INSURANCE

Primary Dental Insurance:_____ ID #:_____ Group #:_____

Claims Mailing Address:_____ City:_____ State:_____ Zip:_____

Subscriber Name:_____ Date of Birth:_____ Sex:_____ Age:_____

Address:_____ City:_____ State:_____ Zip:_____

Billing Address (if different):_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell:_____ E-Mail:_____

SS #:_____ Employer/Occupation:_____ Business Phone:_____

Employer Address:_____ City:_____ State:_____ Zip:_____

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employs any such assistance as he/she deems appropriate.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company (if applicable), consulting professionals or others that may request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

Signature of Patient, Parent or Guardian:

_____ Date:_____