PATIENT INFORMATION

Patient's Name: Last First Middle			**Today's Date:**
Mailing Address:			
City	**State**	**Zip:**	**Email:**
Home Phone:	**Cell Phone:**		**Work Phone:**
Birth Date:	**Social Security No.**	**Sex:** **M** ☐ **F** ☐	**Marital Status:**
Who may we thank for referring you?			

EMERGENCY CONTACT INFORMATION (Required by Law)

Emergency Contact Person Last First Middle			**Relationship to patient:**
Mailing Address:			
City, State, Zip:			**Email:**
Home Phone:	**Cell Phone:**		**Work Phone:**

☐ Same as Patient **RESPONSIBLE PARTY INFORMATION**

Full Legal Name: Last First Middle			**Relationship to patient:**
Mailing Address:			**Phone:**
City, State, Zip:			**SSN:**
Dental Insurance Co:	**Employer Name**	**Birth Date:** m/d/yy	**Member ID#:**

Do you have Secondary Dental Insurance: **Yes** ☐ **No** ☐

Please present your Dental Insurance Card to the front desk.

HEALTH INFORMATION

Physician Name:	**Physician Phone:**

Drug Allergies:	**Latex Allergy? Y N**

Do you or have you ever had any of the following conditions:

- ☐ Angina Pectoris
- ☐ Heart Attack
- ☐ Atrial Fibrillation
- ☐ Heart Bypass
- ☐ Heart Surgery
- ☐ Congenital Heart Defect
- ☐ Artificial Heart Valve
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Fever
- ☐ Pace Maker
- ☐ Stent or Shunt
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Asthma
- ☐ Hepatitis A, B, C
- ☐ Arthritis
- ☐ Cancer-Chemotherapy
- ☐ Radiation Therapy
- ☐ Tumor
- ☐ Artificial Bone/Joint
- ☐ Organ Transplant
- ☐ Thyroid Problems
- ☐ Diabetes
- ☐ Kidney Problems
- ☐ Fainting Spells
- ☐ Epilepsy
- ☐ Seizures
- ☐ Glaucoma
- ☐ Liver Disease
- ☐ Blood Disorder
- ☐ Colitis
- ☐ Ulcers
- ☐ Gastric Reflux
- ☐ Tuberculosis
- ☐ HIV – AIDS
- ☐ Venereal Disease
- ☐ Sinus Problems
- ☐ Allergies/ Hay Fever
- ☐ Headaches – Migraines
- ☐ Depression
- ☐ Anxiety / Nervousness
- ☐ ADHD/ ADD
- ☐ Other _____

If female please answer the following:

Y	**N**	
☐	☐	Are you taking Birth Control Pills or Injection?
☐	☐	Are you pregnant? If Yes, # of weeks?
☐	☐	Are you nursing?

Do you smoke or chew tobacco? Y N
How much? _____

Height: _____ Weight: _____

☐ **Is there any disease, condition, surgery or problem that you think this office should know about not covered previously?**

Please list All Medications, Supplements and Vitamins on this sheet.

Medication Name:	**Dosage**