MR.
MRS.
MS.
DR. DATE DATE OF BIRTH

MAILING ADDRESS CELL PHONE TEXT YES ❑ NO ❑

CITY STATE ZIP ALTERNATE PHONE #

EMPLOYER BUS. PHONE

ADDRESS CITY STATE ZIP

EMAIL ADDRESS

LIST ANY METHOD OF COMMUNICATION YOU **DO NOT** WANT US TO USE:

MAY WE LEAVE A MESSAGE AT ANY OF THE LISTED PHONE #'S? YES ❑ NO ❑

GENERAL DENTIST
REFERRED BY PHYSICIAN

DENTAL INSURANCE COMPANY INSURANCE PHONE # GROUP NO.

NAME OF INSURED DATE OF BIRTH OF INSURED / /

INSURED'S SOC. SEC. NO. OR ID NO.

PERSON RESPONSIBLE FOR YOUR ACCOUNT PHONE #

PERSONS AUTHORIZED TO ACCESS MY RECORDS

RELATIONSHIP TO YOU DATE OF BIRTH

EMERGENCY CONTACT PHONE #

PAYMENT DUE AT TIME OF SERVICE

PLEASE CIRCLE DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING ?

Yes No Rheumatic Fever or Rheumatic Heart Disease?
Yes No Have you been told by a physician that you must premedicate with antibiotics prior to all dental visits?
Yes No Heart Murmur or Congenital Heart Disease?
Yes No Pacemaker? or Heart Surgery? (please circle) Date: ____________________
Yes No Shortness of Breath or Chest Pain on Exertion?
Yes No High Blood Pressure? Taking Meds? (please name)____________________
Yes No Seizures or Convulsions? Name ____________________
Yes No Diabetes ?
Yes No Arthritis ?
Yes No Thyroid Disease ?
Yes No Sexually Transmitted Disease?
Yes No Hepatitis?
Yes No Liver Disease or Jaundice?
Yes No Bleeding Disorder or Anemia?
Yes No Tuberculosis?
Yes No Asthma? - If yes do you carry an inhaler? Yes No
Yes No Artificial Joint Replacement or Heart Valve? Name Joint____________________ year __________

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING ?

Yes No Penicillin?
Yes No Novocaine or other Local Anesthetic?
Yes No Aspirin?
Yes No Codeine or other Narcotics? ____________________
Yes No Latex?
Yes No Other Allergies? ____________________

Yes No **ARE YOU TAKING MEDICATION NOW ?**

Name of Medication____________________ Condition being treated ____________________

____

WOMEN - Please advise us of pregnancy or possible pregnancy or any other condition which we should be aware of?

____

PATIENT'S SIGNATURE:____________________ **DATE** __________
(or parent if patient is a minor)