

MEDICAL HISTORY AND INFORMATION

Mr./Mrs./Miss Name _____ Age _____ Birth Date _____ Soc. Sec. No. _____
 Res. Address _____
 City _____ State _____ Zip _____
 Cell Phone _____ Bus. Phone _____ Res. Phone _____
 Employed By _____ Occupation _____
 Spouse's Name _____ Spouse's Employer _____ Spouse Phone _____
 Person Financially Responsible for Account _____
 Address _____ Phone _____
 Whom may we thank for referring you to us? _____
 Name of person to call in emergency _____ Phone _____
 Physician _____ Office Phone _____

Dental Insurance:

Policy Holder's Name _____ Name of Plan _____
 Policy Holder's Birth Date _____ Policy Holder's Member ID. _____

I AGREE TO BE RESPONSIBLE FOR ALL CHARGES FOR DENTAL SERVICES AND MATERIALS NOT PAID BY MY DENTAL BENEFIT PLAN, UNLESS THE TREATING DENTIST OR DENTAL PRACTICE HAS A CONTRACTUAL AGREEMENT WITH MY PLAN PROHIBITING ALL OR A PORTION OF SUCH CHARGES. TO THE EXTENT PERMITTED UNDER APPLICABLE LAW, I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO MY CLAIMS.

SIGNATURE: _____ DATE: _____

****OUR FEE POLICY: To help control costs, we ask our patients to pay for their office visit at the time service is rendered unless other arrangements have been made.**
**** A TWO WORKING DAY NOTICE is required to avoid a possible cancellation fee.**

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

YES/NO Rheumatic Fever	YES/NO Prosthetic Replacement (i.e. hip, knee)	YES/NO Venereal Disease
YES/NO Heart Problems	YES/NO Hepatitis, _____	YES/NO Are you Pregnant now
YES/NO Heart Murmur	YES/NO Hyperthyroid, Hypothyroid	YES/NO Fainting Spells
YES/NO Prosthetic Heart Valves	YES/NO Asthma/Bronchitis	YES/NO Cancer
YES/NO Open Heart Surgery	YES/NO Epilepsy, Seizures	YES/NO Radiation/Chemotherapy
YES/NO Stroke or Heart Attack	YES/NO Arthritis	YES/NO Fen-Phen, Redux
YES/NO Pace Maker	YES/NO Tuberculosis	YES/NO Tobacco User
YES/NO High Blood Pressure	YES/NO Diabetes	YES/NO Depression/Anxiety
YES/NO Angina	YES/NO Herpes	YES/NO Dental Anesthetic Reaction
YES/NO Blood Disorders, Bleeder	YES/NO AIDS-HIV	YES/NO Other:

1. Please list allergies and medication you are allergic to:
2. Are you under the care of a physician? If yes, for what purpose?
3. Have you had dental X-rays taken within the past 12 months? (yes no) If so, where?
4. Please add any additional health information:
5. List Medications: _____

Signature **X** _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____