Today’s Date \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_ Home phone (\_\_\_\_\_)\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ Cell phone (\_\_\_\_\_)\_\_\_\_\_\_-\_\_\_\_\_\_\_\_

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M F Age\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 LAST NAME FIRST NAME MI sex Marital status PREFERRED NAME

 Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Apt \_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_ Zip\_\_\_\_\_\_\_

**INSURANCE**

**Name of Subscriber**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN or ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s birth date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Name of Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Co: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Subscriber**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN or ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s birth date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Name of Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Co: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DENTAL HISTORY**

Do you like your smile? **YES NO** Is there anything you would like to change about your smile? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any unhappy experience in a dental office? **YES NO** what happened? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like to be sedated for your dental treatment? **YES NO**

Do you snore? **YES NO** Have you ever been diagnosed with sleep apnea? **YES NO**

**MEDICAL HISTORY**

Physician’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last physical \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_

Physician’s address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_ MRN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any of the following?

\_\_\_\_\_Mitral valve Prolapse \_\_\_\_\_Heart Murmur \_\_\_\_\_Back Problems

\_\_\_\_\_Epilepsy \_\_\_\_\_Psychiatric Care \_\_\_\_General Allergies(dust/pollens)

\_\_\_\_\_Swollen Neck Glands \_\_\_\_\_HIV/AIDS \_\_\_\_\_Venereal Disease

\_\_\_\_\_High Blood Pressure \_\_\_\_\_Radiation Treatment \_\_\_\_\_Diabetes

\_\_\_\_\_Rheumatic Fever \_\_\_\_\_Chronic Diarrhea \_\_\_\_\_Blood Disease

\_\_\_\_\_Low Blood Pressure \_\_\_\_\_Artificial Heart Valve or Joint \_\_\_\_\_Chemical Dependency

\_\_\_\_\_Hepatitis Jaundice, or Liver disease \_\_\_\_\_Allergies to Anesthetics \_\_\_\_\_Respiratory Disease

\_\_\_\_\_Sinus Problems \_\_\_\_\_Stroke \_\_\_\_\_Arthritis

\_\_\_\_\_Circulatory Problems \_\_\_\_\_Recent Weight Loss \_\_\_\_\_Hemophilia

\_\_\_\_\_Cancer Type?\_\_\_\_\_\_\_\_\_\_

Do you have any drug allergies or have you ever had an adverse reaction to any medication? **YES NO** IF so, what?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever used Phen Phen **YES NO** Are you allergic to Latex **YES NO**

Have you ever responded adversely to medical or dental treatment? **YES NO** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking Medications **YES NO** if so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you under the care of a physician? **YES NO** if so, for what condition\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Women) Do you suspect that you are pregnant? **YES NO** Are you Nursing **YES NO**

Is there anything else we should know about your medical history?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency, who should we notify? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_\_\_\_

Who is responsible for the account? ­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_