Welcome Thank you for selecting our dental office. We will strive to provide you with the best possible dental care. To help us meet your dental health needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us -- we will be happy to help!

Today's date _____

Patient Information:

Name _____ Home Phone _____

Address _____ Business Phone _____

City, State, Zip _____ Birthdate _____

Cell Phone Number _____ Email Address: _____

Social Security # _____ Employer _____ Occupation _____

Height _____ Weight _____ Sex M F Marital Status: Single Married Widowed Divorced

Name of Spouse _____ Referred by _____

Account/Insurance Information:

Person responsible for account: _____ Relationship to patient _____

Address _____ Home Phone _____ Business Phone _____

City, State, Zip _____ Social Security # _____ Date of Birth _____

Occupation _____ Employer Name & Address _____

Insurance Company Name & Telephone # _____

Do you have additional Insurance? Y N If yes what _____

Do you have any areas of concern about your teeth or mouth?

_____

Dental History

When was your last dental visit? _____ Last dental x-rays? _____

How frequently do/did you go to the dentist? _____

What types of dental treatment have you had? _____

Any difficulties with past treatment _____

Adverse reactions to "novocaine", latex gloves etc. _____

Medical History

Are you now or have you been under a physician's care in the last 12 months? Y N If yes, why

_____

Name of Physician _____ Phone # of physician _____

Have you ever been hospitalized? Y N If yes, for what: _____

Do you have any allergies or sensitivities? Y N If Yes, to what: _____

Do you take any medications? Y N If yes, what: _____

For Females Only: Do you take oral contraceptives Y N Are you pregnant Y N

Any changes in your menstrual pattern Y N