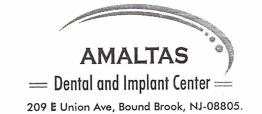
Confidential Patient Information

(Please Print Legibly)

Date:			
Date	 	 	



PERSONAL INFORMATION

Name:	SS#:	
Address:		
City:	State:	Zip:
Telephone: (Home)	(Work)	
(Cell)	E-Mail:	· · · · · · · · · · · · · · · · · · ·
Birth date:Sex:Ma	arital Status: Spouse	Name:
Occupation:	Referred by:	
PERSON RESPONSIBLE FOR	R ACCOUNT	
Name:	Relationship:	SS#:
Address:		
City:	Sta	te: Zip:
Telephone: (Home)	(Work)	
DENTAL INSURANCE INFOR	RMATION	
Primary Insurance Co:		
Employee:	Relationship:	S.S.#:
Employer:	Polic	y #:
Secondary Insurance Co:		
Insurance Co: Address:		
Employee:	Relationship:	S.S.#:
Employer:	Polic	y #:

INSURANCE: To avoid misunderstandings regarding dental insurance, we want patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our service on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

I understand that payment is my obligation regardless of insurance or any other third- party involvement.

SIGNATURE:		DATE:	

DENTAL HISTORY

CHIEF ORAL COMPLAINT				
DATE OF LAST EXAM ANY PREVIOUS MAJOR DENTAL TREATMENT: YES NO, IF YES, WHEN:				
DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING- INDICATE WITH A (~)				
Teeth sensitive to cold, heat, sweets or pressure Bleeding gums. How long?				
Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.				
Are you under a physician's care now?				
Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No				
- Are you allergic to any of the following? Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs Other If yes, please explain:				
AIDS/HIV Positive				
To the best of my knowledge, the question on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.				
SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE				