MEDICAL HISTORY

Name:________________________________ Birth Date: _____________

Are you under a physician's care now? Y N If yes, please explain:________________________________

Have you ever been hospitalized or had a major operation? Y N If yes, please explain:________________________________

Are you taking any medications, pills, or drugs? Y N If yes, please explain:________________________________

Do you take, or have you taken, Phen-Fen or Redux? Y N ____

Are you on a special diet? Y N ____

Do you use tobacco? Y N

Do you use controlled substances? Y N

Women: Are you pregnant, trying to get pregnant, nursing? Y N

Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local anesthetics Other

Do you have, or have you had, any of the following?

AIDS/HIV	Chest Pains	Frequent Headaches	Irregular Heartbeat	Scarlet Fever
Alzheimer's Disease	Cold Sores	Genital Herpes	Kidney Problems	Shingles
Anaphylaxis	Congenital heart disorder	Glaucoma	Leukemia	Sickle Cell Anemia
Anemia	Convulsions	Hay Fever	Liver Disease	Sinus Trouble
Angina	Cortisone Medicine	Heart Attack/Failure	Low Blood Pressure	Spina Bifida
Arthritis/Gout	Diabetes	Heart Murmur	Lung Disease	Stomach/intestinal Disease
Artificial Heart Valve	Drug Addiction	Heart Pacemaker	Mitral Valve Prolapse	Stroke
Artificial Joint	Easily Winded	Heart Trouble/Disease	Pain in Jaw Joints	Swelling of Limbs
Asthma	Emphysema	Hemophilia	Parathyroid Disease	Thyroid Disease
Blood Disease	Epilepsy or Seizures	Hepatitis A	Psychiatric Care	Tonsillitis
Blood Transfusion	Excessive Bleeding	Hepatitis B or C	Radiation Treatments	Tuberculosis
Breathing Problem	Excessive Thirst	Herpes	Recent Weight Loss	Tumors or Growths
Bruise Easily	Fainting Spells/Dizziness	High Blood Pressure	Renal Dialysis	Ulcers
Cancer	Frequent Cough	Hives or Rash	Rheumatic Fever	Venereal Disease
Chemotherapy	Frequent Diarrhea	Hypoglycemia	Rheumatism	Yellow Jaundice

Have you ever had any serious illness not listed above? Y N If yes, please explain:________________________________

PRESCRIPTION OR NONPRESCRIPTION MEDICINE LIST:

____ ____

____ ____

____ ____

____ ____

____ ____

____ ____

PATIENT REGISTRATION

First Name:____________________________ Last Name:____ Middle Initial:_____

Patient is: Policy Holder
Responsible Party
Preferred Name:_________________________________

RESPONSIBLE PARTY *(If someone other than the patient)*

First Name:____________________________ Last Name:____ Middle Initial:_____

Address:____ Address 2:____

City, State, Zip:____ Pager:_________________

Home Phone:_______________________ Work Phone:________________________ Ext:_______ Cellular:__________________

Sex: M F Marital Status: Married Single Divorced Separated Widowed

Birth Date:________________________ Age:______ Social Security #:_____________________ Drivers License #___________________

E-mail:___________________________________ I would like to receive email correspondence Y N

Employment Status: Full Time Part Time Other _____________ Referred By:____________________________________

Student Status: Full Time Part Time

Previous Dentist:_______________________________

Medicaid ID:_________________________

Emergency Contact:______________________________

Employer ID:________________________ Pref. Pharmacy__________________

Spouse's Work #________________________________

Carrier ID:__________________________ Pref. Hygienist___________________

PRIMARY INSURANCE INFORMATION

Name of Insured:____ Relationship to Insured: Self Spouse Child Other

Insured Social Security #____________________________________ Insured Birth Date:_______________________

Employer:____

Insurance Company:____

Address:____

Address:____

Address 2:____

Address 2:____

City, State, Zip:_____________________________________

City, State, Zip:____

Remaining Benefits____________ Remaining Deductions____________

SECONDARY INSURANCE INFORMATION

Name of Insured:____ Relationship to Insured: Self Spouse Child Other

Insured Social Security #____________________________________ Insured Birth Date:_______________________

Employer:____

Insurance Company:____

Address:____

Address:____

Address 2:____

Address 2:____

City, State, Zip:_____________________________________

City, State, Zip:____

Remaining Benefits____________ Remaining Deductions____________