Patient Name____ **Preferred Name**_________________________
(First) (M.I.) (Last)
Street Address ____**Apt.**_________________________

City_____________________________________**State**__________**Zip**___________________________________

Home #:________________________ **Cell #:**___________________________ **Work#:** ____________________

Sex: M F Age_____ **Birthdate** ______/______/______ **Single/Married/Separated/ Divorced/Widowed/Child**

Parent/Responsible Party Name ____
(If applicable)

Employer____________________________________ **Occupation**______________________________________

Do you have a Gmail account?_________________________ **E-mail**___________________________________

Patient SS#_______-_______-_______ **Parent/Responsible SS#**_______-_______-______ **DOB**____________

Primary Dental Insurance Carrier________________________**Group Policy #**_________________________

Subscriber:___________________________**DOB:**_________________**ID#:**____________________________

Secondary Dental Insurance Carrier_____________________**Group Policy #**____________________________

Subscriber:___________________________**DOB:**_________________**ID#:**____________________________

How did you hear about us?____

Reason for Appointment____

Medical History

Physicians Name_____________________________________Last Seen__________________________________

Are you under a physician's care?____________For what?____

Have you ever had any of the following? (Please circle)

Heart Murmur	**Blood Disease**	**Cancer**
Diabetes	**Asthma**	**Seizures**
Mitral Valve Prolapse	**Respiratory Disease**	**Thyroid Disease**
Hepatitis or Liver Problems	**Heart Attack**	**Nervousness/Depression**
High Blood Pressure	**Stroke**	**Kidney Problems**
Other:________________________________		**Latex Allergy**

Do you have any drug allergies?_______ If so, what____

List any current Medications:____

Do you need to pre-med before appointments? Y / N If yes, for what?_____________________________________

(Women) Are you Pregnant? Y or N Are you currently nursing? Y or N

Last Dental Visit_________________________ For What____

____________________________ ___________ ____
Patient Signature (Parent if child) **Date** **Dentist Signature**