

Date \_\_\_\_\_

**PATIENT INFORMATION**

\_\_\_\_\_ Mr./Mrs./Ms/Dr  
(Last Name) (First Name) (Middle Name)

Nickname \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex M/F SS# \_\_\_\_\_

Address \_\_\_\_\_  
(Street) (City) (State) (Zip code)

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_ Email \_\_\_\_\_

Spouse's Name \_\_\_\_\_  
Employer/  
Occupation \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone #: \_\_\_\_\_

I consent to the taking of photographs and x-rays before, during and after treatment, and to the use of same by the doctor in educational papers, displays or demonstrations.  
I also authorize the release of any information, including the diagnosis and the records of any treatments or examinations rendered to my insurance company or companies.

\_\_\_\_\_  
Signature

Whom/what source may we thank for your referral: \_\_\_\_\_

**BILLING INFORMATION**

**PERSON RESPONSIBLE FOR PAYMENT:**

\_\_\_\_\_ Mr./Mrs./Ms/Dr  
(Last Name) (First Name) (Middle Name)

**Mailing Address**

\_\_\_\_\_  
(Street) (City) (State) (Zip)

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_ Email \_\_\_\_\_

Employer \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_

**INSURANCE INFORMATION**

Policyholder \_\_\_\_\_ SS# \_\_\_\_\_ Birthdate \_\_\_\_\_ Group# \_\_\_\_\_

Employer \_\_\_\_\_

Insurance Co. #1 \_\_\_\_\_  
(Name) (Address)

Policyholder \_\_\_\_\_ SS# \_\_\_\_\_ Birthdate \_\_\_\_\_ Group# \_\_\_\_\_

Employer \_\_\_\_\_ (OVER)

Insurance Co. # 2 \_\_\_\_\_  
(Name) (Address)

What are your hobbies or special interests? (For example, sports, self-improvement, education)

Do you or have you had any of the following:

AIDS or HIV infection	Y/N	Gastrointestinal/Digestive Problems	Y/N
Anemia	Y/N	If yes, specify: _____	
Arthritis	Y/N	Glaucoma	Y/N
Asthma	Y/N	Hepatitis, Jaundice or liver disease	Y/N
Blood transfusion. If yes, date: _____	Y/N	Joint replacement: If yes, when _____	Y/N
Cancer/Chemotherapy/Radiation Treatment	Y/N		
Cardiovascular disease: If yes, specify below:		Kidney problems	Y/N
___Artificial heart valves	___High blood pressure	Nervous Disorder	Y/N
___Heart Attack	___Low blood pressure	Severe headaches/migraines	Y/N
___Heart Murmur	___Mitral valve prolapse	Sinus trouble/Allergies	Y/N
___Stent	___Pacemaker	Sleep disorder	Y/N
Diabetes: If yes, specify below:	Y/N	Sores or ulcers in the mouth	Y/N
___Type I (insulin dependent)	___Type II	Stroke	Y/N
Epilepsy	Y/N	Tuberculosis	Y/N
Excessive/Abnormal bleeding	Y/N	Thyroid problems	Y/N
Fainting spells or seizures	Y/N	Osteoporosis	Y/N
Are you or could you be pregnant?	Y/N _____ #Mos		
Nursing?	Y/N		

Have you seen your physician or been hospitalized in the last two years?

If yes, please explain (list all surgical procedures & dates in your lifetime) \_\_\_\_\_

Physician's Name, Address & Phone \_\_\_\_\_

Do you smoke? Y/N If yes, how much and how often: \_\_\_\_\_

Do you drink alcohol? Y/N If yes, how much and how often: \_\_\_\_\_

Do you have any instructions from a physician to take antibiotics for dental work? Y/N If yes, what? \_\_\_\_\_

Have you had unfavorable reactions &/or are you allergic to any of the following (please circle)

Aspirin	Codeine	Anesthetics	Novocaine	Sedatives
Latex	Sulfa	Penicillin/Antibiotics	Other Drugs (list) _____	

Please list all drugs currently being taken:

\_\_\_\_\_

The information above is correct to the best of my knowledge. I give my consent to have the treatment recommended for my benefit (or for my minor child) only after it has been mutually approved.

\_\_\_\_\_ Date \_\_\_\_\_

(Signature)

\_\_\_\_\_ Date \_\_\_\_\_

(Signature)