MEDICAL HISTORY AND INFORMATION

Mr./Mrs./Miss Soc. Sec. No. _____
Name _____ Age _____ Birth Date _____
Res. Address _____ Res. Phone _____
City_____ State _____ Zip _____
Cell Phone_____ Bus. Phone _____
Employed By _____ Occupation _____
Spouse's Name _____ Spouse's Employer _____ Bus. Phone _____
Person Financially Responsible for Account _____
Address _____Phone _____
Whom may we thank for referring you to us? _____
Name of person to call in emergency _____ Phone _____
Physician _____ Office Phone _____

Dental Insurance:
Insured Person's Name _____ Name of Plan _____
Insured Person's Birth Date_____ Insured Person's Member ID._____

I AGREE TO BE RESPONSIBLE FOR ALL CHARGES FOR DENTAL SERVICES AND MATERIALS NOT PAID BY MY DENTAL BENEFIT PLAN, UNLESS THE TREATING DENTIST OR DENTAL PRACTICE HAS A CONTRACTUAL AGREEMENT WITH MY PLAN PROHIBITING ALL OR A PORTION OF SUCH CHARGES. TO THE EXTENT PERMITTED UNDER APPLICABLE LAW, I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO MY CLAIMS.

SIGNATURE:_____DATE:_____

*****OUR FEE POLICY: To help control costs, we ask our patients to pay for their office visit at the time service is rendered unless other arrangements have been made.***
***** A TWO WORKING DAY NOTICE is required to avoid a possible cancellation fee.***

Do you have, or have ever had any of the following:

YES/NO Rheumatic Fever	***YES/NO*** Prosthetic Replacement (i.e. hip, knee)	***YES/NO*** Venereal Disease
YES/NO Heart Problems	***YES/NO*** Hepatitis, _____	***YES/NO*** Are you Pregnant now
YES/NO Heart Murmur	***YES/NO*** Hyperthyroid, Hypothyroid	***YES/NO*** Fainting Spells
YES/NO Prosthetic Heart Valves	***YES/NO*** Asthma/Bronchitis	***YES/NO*** Cancer
YES/NO Open Heart Surgery	***YES/NO*** Epilepsy, Seizures	***YES/NO*** Radiation/Chemotherapy
YES/NO Stroke or Heart Attack	***YES/NO*** Arthritis	***YES/NO*** Fen-Phen, Redux
YES/NO Pace Maker	***YES/NO*** Tuberculosis	***YES/NO*** Tobacco User
YES/NO High Blood Pressure	***YES/NO*** Diabetes	***YES/NO*** Depression/Anxiety
YES/NO Angina	***YES/NO*** Herpes	***YES/NO*** Dental Anesthetic Reaction
YES/NO Blood Disorders, Bleeder	***YES/NO*** AIDS-HIV	***YES/NO*** Other:

1. Please list allergies and medication you are allergic to:
2. Are you under the care of a physician? If yes, for what purpose?
3. Have you had dental X-rays taken within the past 12 months? (yes no) If so, where?
4. Please add any additional health information:
5. List Medications: _____ _____ _____

Signature **X** _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature_____Date_____