Date _____/_____/_____

Patient's Name ____

Purpose of Call ____

Patient's DOB ___________ Patient's Social Security # ____________

Driver's License #______________ Male ❑ Female ❑ Minor ❑

Married ❑ Single ❑ Separated ❑ Widower ❑ Widow ❑

Street ____ Apt. # ___

City __________________________ State_____ Zip Code __________

Home Phone ______ - _____ - _____ Cell Phone ______-_____- ______

Work Phone ______-______- ______ EMAIL _____________________

Parent's Name (if Minor) ______________ _________________________

Patient Employed By ____

Address _______________________ Work # ______________

Present Position _________________ How long held _________

Name of Spouse ____

Employer ____

Address _______________________ Work # ______________

Present Position _________________ How long held _________

REFERRED BY ____

Person Responsible For This Account ____________________________

And Social Security Number _______- _______ -_______

Name of **DENTAL INSURANCE** Company___________________________

Group # __________________ ID# _______________________

Name of Insured ______________________ Insured's DOB _________

Address to Mail Claims To

____

Phone ____

Name of Physician (General Practitioner)_______________________________

Phone __________________ Date of Last Medical Examination ________

Do You Have or Have you Ever Had:	Yes	No
Anemia	___	___
Diabetes	___	___
Allergies		
To Penicillin	___	___
To Codeine	___	___
To Local Anesthetic	___	___
To Latex	___	___
Other _________________________		
Abnormal Heart Condition	___	___
Abnormal Bleeding From A Cut	___	___
Rheumatic Fever	___	___
Hepatitis ❑A ❑B ❑C		
AIDS	___	___
HIV Positive	___	___

Please list current medication you are taking, including OTC ____________

____

Do you currently Pre-Med prior to Dental Visits? YES NO

Other Physical Conditions ____________________________________

Are You Pregnant? YES NO

Are You Under the Care of a Physician now? YES NO

Name ______________________________ Phone #______________

Last Dental Visit _________

Name of prior Dentist _________________ Phone # ______________

Have you avoided dental treatment in the past? YES NO

If yes, why? ____

Patient Signature ____

DATE	SERVICE RENDERED	CHARGE