



Please download and complete this form to be returned to the office.

PATIENT INFORMATION
NAME: LAST FIRST MIDDLE MALE FEMALE
SOCIAL SECURITY #: MARITAL STATUS: S M DOB: AGE:
TELEPHONE (HOME): ( ) CELL: ( )
TELEPHONE (WORK): ( ) EMAIL:
ADDRESS: # STREET NAME APT. # CITY STATE ZIP CODE
EMPLOYER:

REFERRAL INFORMATION
TV MAIL POSTCARD INTERNET YELLOW PAGES WELFARE OFFICE: NAME OF REP.
FRIEND OR RELATIVE (NAME): OTHER:

SPOUSE OR RESPONSIBLE PARTY INFORMATION
THE FOLLOWING IS FOR: THE PATIENT'S SPOUSE THE PATIENT'S PARENT PERSON RESPONSIBLE FOR PAYMENT
NAME: MALE FEMALE MARRIED SINGLE
SOCIAL SECURITY #: DATE OF BIRTH:

HEALTH INFORMATION
DATE OF LAST DENTAL VISIT: REASON FOR THE VISIT:
DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING? CHECK THOSE THAT APPLY:
AIDS ANEMIA ARTHRITIS ASTHMA ALLERGIES ARTIFICIAL JOINTS BLOOD DISEASE CANCER DIABETES DIZZINESS EPILEPSY FAINTING RADIATION TREATMENT
GLAUCOMA HEAD INJURIES HEART DISEASE HEART MURMUR HEPATITIS A B C HIGH BLOOD PRESSURE JAUNDICE KIDNEY DISEASE LIVER DISEASE PACEMAKER GROWTHS ARE YOU PREGNANT: YES NO DUE DATE:
RESPIRATORY PROBLEMS RHEUMATIC FEVER RHEUMATISM SINUS PROBLEMS STOMACH PROBLEMS STROKE TUBERCULOSIS ULCERS VENERAL DISEASE CODEINE ALLERGY PENICILLIN ALLERGY OTHER: OTHER:
ARE YOU UNDER THE CARE OF A PHYSICIAN? YES NO
IF YES, PLEASE EXPLAIN: NAME OF PHYSICIAN: TELEPHONE #: ( )
ARE YOU TAKING ANY MEDICATIONS, PILLS OR DRUGS? YES NO
IF YES, PLEASE EXPLAIN:
DO YOU TAKE ANY BLOOD THINNERS ? YES NO ASPIRIN PLAVIX COUMADIN OTHER:
TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS AND INFORMATION PROVIDED ARE TRUE AND CORRECT. IF I HAVE ANY CHANGES IN MY HEALTH, I WILL INFORM THE DOCTORS AT THE NEXT APPOINTMENT WITHOUT FAIL.