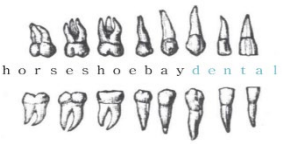

PATIENT INFORMATION

Name:_____ Occupation:_____

Address:_____ Male___ Female____

City:_____ State:_____ Zip:_____ Phone: _____

Employer:_____ Work Number:_____

DOB: _____ SSN: _____ Email: _____

RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)

Name: _____ Address: _____

City:_____ State:_____ ZIP:_____ DOB:_____

SSN:_____ Cell:_____ Relationship:_____

SOME OF OUR SERVICE MAY BE COVERED BY YOUR MEDICAL INSURANCE

Medical Insurance

Ins. Company Name:_____ Subscriber Name:_____

Policy Number:_____ Group Number:_____

Address:_____ Phone Number:_____

Relationship to the Patient:_____ DOB:_____ SSN:_____

Dental Insurance

Ins. Company Name:_____ Subscriber Name:_____

Policy Number:_____ Group Number:_____

Address:_____ Phone Number:_____

Relationship to the Patient:_____ DOB:_____ SSN:_____

WHAT IS MOST IMPORTANT TO YOU IN A DENTIST, DENTAL TEAM, AND ORAL HEALTH

_____

_____

DO YOU HAVE ANY COSMETIC CONCERNS THE DOCTOR SHOULD BE AWARE OF

_____

_____

I AUTHORIZE THE DENTIST TO PERFORM DIAGNOSTIC PROCEDURES AND TREATMENT AS MAY BE NECESSARY FOR PROPER DENTAL CARE. I ALSO AUTHORIZE THE RELEASE OF ANY INFORMATION CONCERNING MY (OR MY CHILDS) HEALTH CARE, MEDICAL HISTORY, ADVICE AND TREATMENT TO ANOTHER DENTIST IF APPLICABLE OR AN INSURANCE COMPANY. SINCE APPOINTMENTS ARE RESERVED EXCLUSIVLY FOR ME, I UNDERSTAND THAT CHARGES WILL OCCUR IF I GIVE LESS THAN 48 HOUR NOTICE OF AN APPOINTMENT CANCELLATION.

SIGNATURE: _____ **DATE:** _____

PATIENT MEDICAL HISTORY

Name: _____Date of Birth: _____ Sex: M F **Today's Date:** _____

Primary Care Physician: _____ Physician's Phone: _____
Physician Address: _____

DRUG ALLERGIES	Head/Ears/Nose/Throat	Pulmonary	
List all **DRUG Allergies:** _____ _____ _____ _____ _____ _____	□Glaucoma □Glasses/Contacts □Cataract/Visual Problems □Hearing Problems □Sore Throat □Food Allergy/Sensitivity □Seasonal/Other Allergies	□Asthma □Cough □Wheezing □Shortness of Breath □Emphysema/COPD □Positive TB Test	□Insomnia □Waking in the Night □Never Feel Rested □Snoring □Sleep Apnea □Use of CPAP □Previous Sleep Study
Cardiac	Gastrointestinal	Metabolic	Psychological
□Chest Pain with Exertion □Chest Pressure □Heart Failure □Palpitations/Irregular Beat □Murmur/Rheumatic Fever □Coronary Artery Disease □Heart Attack	□Abdominal Pain □Trouble Swallowing □Nausea/ Vomiting □Fatty Liver/Liver Disease □Stomach Ulcers □Heartburn or Acid Reflux □Gallbladder Disease	□High Blood Pressure □Diabetes □High Cholesterol □Thyroid Problems □Anemia □Other_____ □Other_____	□Depression □Anxiety □Stress □Emotional Eating □Ever received psychiatric treatment or counseling □Mental Illness
Hematological	Neurological	Musculoskeletal	
□Abnormal Bleeding □Easy Bruising □Blood Clots in Legs/Lungs □HIV/AIDS □Nose Bleeds □Hepatitis B or C □Leukemia	□Neurologic Disease □Chronic Headaches □Migraines □Dizziness □Passing Out □Seizure/Epilepsy □Stroke	□Joint Pain □Back Pain □Leg Pain/Cramps □Leg Ulcers □Varicose Veins □Broken Bones	Do you: **SMOKE? Y/N**____packs/day x ___years **Use of TOBACCO? Y/N**_____How/How Often?

ARE YOU TAKING ANY BLOOD THINNERS □ YES □ NO
Pre-med for dental appointment □ YES □ NO

Current Medication List **Reason for Taking**

_____

_____

_____

_____

_____

Patient Signature_____ Date _____
Your signature indicates the above information is complete and true.