WELCOME TO FAMILY DENTAL PRACTICE

PATIENT INFORMATION (PLEASE PRINT)

PATIENT'S NAME:	MARITAL STATUS (S / M / W / D / SEP)	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.
STREET ADDRESS PERMANENT TEMPORARY	CITY AND STATE		ZIP CODE	HOME PHONE NO.
PATIENT'S OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF A STUDENT)	HOW LONG EMPLOYED		BUS. PHONE NO.
EMPLOYER'S STREET ADDRESS	CITY AND STATE		ZIP CODE	EXTENSION
SPOUSE OR PARENT'S NAME	NUMBER OF CHILDREN AND AGES			
PERSON RESPONSIBLE FOR PAYMENT	STREET ADDRESS, CITY, STATE & ZIP CODE			HOME PHONE NO.
SPOUSE'S EMPLOYER	SPOUSE'S OR PARENT'S SOCIAL SECURITY #			
WHOM MAY WE THANK FOR REFERRING YOU?				

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	ADDRESS AND PHONE #	GROUP NUMBER	
INSURED'S NAME	RELATIONSHIP TO YOU	INSURED'S SOCIAL SECURITY NO.	DATE OF BIRTH
SECONDARY INSURANCE COMPANY	ADDRESS AND PHONE #	GROUP NUMBER	
INSURED'S NAME	RELATIONSHIP TO YOU	INSURED'S SOCIAL SECURITY NO.	DATE OF BIRTH

MEDICAL HISTORY PHYSICIAN'S NAME ______________________________ DATE OF LAST PHYSICAL EXAM ______________________________

PREVIOUS DENTIST'S NAME ______________________________ DATE OF LAST THOROUGH DENTAL EXAM ____________

ANSWER ALL QUESTIONS (Check "YES" OR "NO")

Y ____ N ____ Angina Pectoris
Y ____ N ____ Heart Murmur
Y ____ N ____ Heart Problems
Y ____ N ____ High Blood Pressure
Y ____ N ____ Mitrovalve Prolapse
Y ____ N ____ Nervous Problems
Y ____ N ____ Psychiatric Treatment
Y ____ N ____ Malignancies
Y ____ N ____ Epilepsy
Y ____ N ____ Mononucleosis
Y ____ N ____ Arthritis

Y ____ N ____ Circulatory Problems
Y ____ N ____ Stroke
Y ____ N ____ Sinus Problems
Y ____ N ____ Asthma
Y ____ N ____ Diabetes
Y ____ N ____ Jaundice
Y ____ N ____ Scarlet Fever
Y ____ N ____ Tonsilitis
Y ____ N ____ Tuberculosis
Y ____ N ____ Ulcer
Y ____ N ____ Excessive Bleeding

Y ____ N ____ Hepatitis
Y ____ N ____ Rheumatic Fever
Y ____ N ____ AIDS
Y ____ N ____ Sexually Transmitted Diseases
Y ____ N ____ Kidney Disease
Y ____ N ____ Artificial Valves
Y ____ N ____ Artificial Bones/Joints

Are You Allergic to any of the following?

Y ____ N ____ Penicillin
Y ____ N ____ Aspirin
Y ____ N ____ Erythromycin
Y ____ N ____ Tetracycline

Y ____ N ____ Codeine
Y ____ N ____ Latex
Y ____ N ____ Anesthetics

List any other allergies:
____
____
____

Are you pregnant? ____________ Have you been hospitalized or had surgery in the last 12 months? ____________

Have you ever been told that you should be pre medicated for medical or dental appointments? ____________

Are you taking any medication? ____________ If yes, What and dosage? ____

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees regardless of insurance coverage. The patient agrees that in the event of any default in payment of account, patient will be liable for attorney's fees and cost of collection which includes a 15% service fee. Routine credit checks are done on all new accounts. A service charge of 1½% per month, 18% annual rate, may be charged on balances due at which time account will be on a cash basis.

____ ____
Signature of patient (or parent if minor) Date

–Office Use Only–

I have reviewed the Medical/Dental information above with the patient named herein.

____ (Signature) ____________________ (Date)