PATIENT HISTORY

HOW WOULD YOU LIKE TO BE REFERRED TO (Nickname):_______________________________DATE:_____________________________

NAME: Ms. Miss / Mr. Atty / Mrs. Dr ____
Last First M.I.

ADDRESS: ____
P.O. Box Street City State Zip

DATE OF BIRTH: ______________________ SOC.SEC. #:______________- _________-____________ □ MALE □ FEMALE

□ Single □ Married
□ Widowed □ Divorced
□ Separated

HOME PHONE: ____________________________ FAX: ________________________________

WORK PHONE: ___________________________ CELLULAR: ________________________ **EMAIL**:__________________________________

Employer: _____________________________________ Address: ____Zip:________________

Occupation: ____________________________________

Payment by: □ Cash □ Check □ Credit Card

Are you interested in financing? □ Yes □ No

Person responsible for the acct: ___________________________

Dental Insurance Carrier: _________________________________

Membership #____

Soc. Sec. #____

Secondary Insurance Carrier: ______________________________

Membership #____

Soc. Sec. #____

Referred to office by: ____________________________________

Name of Physician: ______________________________________

Address: ____

Phone: ____

Date of last visit: ____

Reason for visit: ____

Spouse's name: ____

Spouse's employer: ____

Employer's address____

Nearest relative: ____

Address: ____

Phone: ____

Last dental cleaning: ____

Last dental treatment: _______________________________________

Reason for leaving previous Dentist: _________________________
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Name of Previous Dentist ____________________________________

Address of Previous Dentist __________________________________

Describe general health: □ Good □ Fair □ Poor

Please circle Y or N If you have or ever had any of the following:

Heart Murmur	Y N	Stroke	Y N	Prosthetic Valves or prosthesis	Y N
Rheumatic Fever	Y N	Hepatitis A	Y N	Pacemaker	Y N
Scarlet Fever	Y N	Hepatitis B	Y N	Hips or Joints Replacement	Y N
Premedication before dental visits	Y N	AIDS – HIV +	Y N	Metal Pins / Plates	Y N
Difficulty Breathing	Y N	Venereal Disease	Y N	Orthodontics	Y N
Difficulty Swallowing	Y N	Tuberculosis	Y N		
Heart Disease	Y N	Diabetes	Y N		
High Blood Pressure	Y N	Ulcer	Y N		
Low Blood Pressure	Y N	Asthma	Y N		
Seizures	Y N	Arthritis	Y N		
Epilepsy	Y N	Pregnant at Present	Y N	Do you use tobacco	Y N
Anemia	Y N	Kidney Disorders	Y N	Do you use alcohol	Y N
Chicken Pox	Y N	Emotional Disease	Y N	Do you use caffeine	Y N
Measles	Y N	Bleeding Problems	Y N		
Mumps	Y N	Difficulty Healing	Y N		
History of Cancer: (Family)	Y N	Allergies to Medications	Y N		

If yes, describe:
____

□ Radiation
□ Chemotherapy

____
Latex Allergy Y N
Significant Weight Loss or gain Y N

Medications: _____________________
____
____
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*** Please tell us who we can thank for referring you to our office, or how you heard about us:**

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Signature