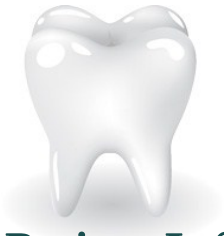

WELCOME to our practice

Patient Information

Today's Date: _____ Birth Date: _____SSN:_____ Male/Female (circle one)

Last Name:_____ First Name:_____ Initial_____ Married/Single

Street Address: _____City:_____State:____Zip:_____

Occupation:_____Employer:_____Wk Phone:_____

Home Phone:_____ **CELL PHONE:**_____

EMERGENCY CONTACT: Name:_____ Relationship:_____

Emergency phone number:_____

Whom may we thank for referring you to us?_____

Primary Insurance

Responsible Party:_____Birthdate:_____

SSN:_____ Relationship to patient:_____

Responsible Party Employer:_____ Business Phone:_____

Business Address:_____Occupation:_____

Insurance Co. Name:_____ Insurance Co. Number:_____

Insurance Co.#:_____Subscriber ID:_____ Group #:_____

Does the patient have Secondary Insurance Coverage? YES / NO

Medical History

Current Medications:

_____

_____

_____

Allergies: **(please circle those that apply)**

Aspirin	**Penicillin**
Barbiturates	**Sulfa**
Codeine	**Iodine**
Latex	**Local Anesthetic**

Other:_____

Familly Health Information: Information that you can furnish us pertaining to your immediate family members will give us a better understanding of your health care needs.

Relationship to you:	Health Condition Past or Present:
_____	_____
_____	_____

PLEASE CIRCLE: CONDITIONS/SYMPTOMS YOU HAVE OR HAVE HAD IN THE PAST YEAR

AIDS
Appendicitis
Arm Pain/Numbness
Arthritis
Asthma
Back Pain/Numbness
Bleeding Disorder
Bleeding Gums
Bloating
Blood in Urine
Blurred Vision
Bowel Changes
Breast Lump
Bright's Disease
Bruise Easily
Bursitis
Cancer
Cataracts
Changing in Moles
Chemical Dependency
Chest Pain
Chicken Pox
Diabetes
Diarrhea
Depression /Nervousness
Difficulty Swallowing
Dizziness/Fainting
Excessive Thirst
Emphysema
Epilepsy
Earache
Foot Pain/Numbness
Fever
Forgetfulness
Frequent Urination
Glaucoma
Hand Pain/Numbness
Hay Fever
Headache
Heart Disease
Hepatitis
Herpes
High Blood Pressure
High Cholesterol
Hip Pain/Numbness
HIV Positive
Hives
Hoarseness
Indigestion
Irregular Heartbeat
Itching
Jaundice
Kidney Disease
Lack of Bladder Control
Leg Pain/Numbness
Liver Disease
Loss of Hearing
Loss of Sleep
Loss of Weight
Low Blood Pressure
Lumbago
Measles
Migraine Headaches
Multiple Sclerosis
Mumps
Nausea
Neck Pain/Numbness
Neuritis
Nose Bleeds
Pacemaker
Painful Urination
Persistent Cough
Pneumonia
Polio
Poor Appetite
Poor Circulation
Prostate Problem
Rapid Heartbeat
Rash
Rheumatic Fever
Ringing in Ears
Scarlet Fever
Scars
Sciatica
Shoulder Pain
Sinus Problems
Sore that won't heal
Stomach Aches/Pains
Stroke
Sweats
Swelling Ankles
Thyroid Problems
Ulcers
Venereal Disease
Vomiting

Please answer the following questions YES/NO then circle HEAVY, LIGHT, MODERATE

Do you drink alcohol?	**YES**	**NO**	**Heavy**	**Moderate**	**Light**
Do you drink coffee?	**YES**	**NO**	**Heavy**	**Moderate**	**Light**
Do use recreational drugs?	**YES**	**NO**	**Heavy**	**Moderate**	**Light**
Do you drink soft drinks?	**YES**	**NO**	**Heavy**	**Moderate**	**Light**
Do you smoke cigarettes?	**YES**	**NO**	**Heavy**	**Moderate**	**Light**
Do you drink water?	**YES**	**NO**	**Heavy**	**Moderate**	**Light**

I certify that all of the information is correct to the best of my knowledge. I will not hold my dentist or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature:_____ **Date:**_____