



## WELCOME TO OUR OFFICE

In order to render optimum health care service it is necessary to become acquainted with the vital information related to each patient. Of course all information is strictly confidential. Although some questions may seem unimportant at the moment they may be vital in case of emergency. Therefore **PLEASE ANSWER EVERY QUESTION.**

## PERSONAL INFORMATION

Date\_\_\_\_\_

Name\_\_\_\_\_ Date of Birth\_\_\_\_\_ Age\_\_\_\_\_

Address\_\_\_\_\_ Home phone\_\_\_\_\_

City\_\_\_\_\_ Office phone\_\_\_\_\_ Cell\_\_\_\_\_

Postal Code\_\_\_\_\_ Sex\_\_\_\_ Marital Status\_\_\_\_\_

Occupation\_\_\_\_\_ e-mail address\_\_\_\_\_

Name of person responsible for this account\_\_\_\_\_

Do you have dental insurance? Yes\_\_\_\_ No\_\_\_\_ S.I.N.\_\_\_\_\_

Name of Policy Holder\_\_\_\_\_

Employer's Name\_\_\_\_\_

Insurance Company\_\_\_\_\_

Group#\_\_\_\_\_ Suffix/Division#\_\_\_\_\_

Certificate or Subscriber ID#\_\_\_\_\_

Whom may we thank for referring you?\_\_\_\_\_

## MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Tele. No. \_\_\_\_\_

Have you been under the care of a doctor or clinic within the last 6 months for any treatment or observation? Yes\_\_\_\_ No\_\_\_\_

Are you now taking or receiving any drugs or medications? Yes\_\_\_\_ No\_\_\_\_

If so, name drug(s) and dosages\_\_\_\_\_

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Have you ever had or been treated for (please circle):

rheumatic fever	heart murmur	heart trouble	stroke
abnormal blood pressure	jaundice	hepatitis	liver disease
kidney disease/infection	diabetes	psychiatric/mental disorders	
epilepsy	cancer	ulcers	A.I.D.S or HIV positive

Do you have or have you ever had an operation or any other serious illness other than the above? Yes\_\_\_\_ No\_\_\_\_

If yes, explain\_\_\_\_\_

Have you ever had asthma, hay fever or hives? Yes\_\_\_\_ No\_\_\_\_



## Authorization

**I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical and dental histories are correct to the best of my knowledge. I understand that my dental insurance (if insured) is a contract between the insurance carrier and me, and not between the insurance carrier and the dentist, and that I am still responsible for all dental fees. I understand that I will be charged for all dental treatment, and that any payments received by the Dental Office from my insurance company will be credited to my account, or refunded to me if I have paid the dental fees incurred.**

**Patients Signature**

**Date**

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