



PERSONAL HISTORY

DATE _____

PATIENT'S NAME (PLEASE PRINT) _____

ADDRESS _____

CITY _____

STATE ZIP _____

MARITAL STATUS: SINGLE MARRIED WIDOWED
 SEPARATED DIVORCED

SEX: MALE FEMALE

PATIENT'S AGE _____ DATE OF BIRTH _____

HOME PHONE NO. _____ WORK PHONE NO. _____

SOC. SECURITY NO. _____

DRIVER'S LIC. NO. _____

PATIENT'S OCCUPATION _____

PATIENT'S EMPLOYER _____

EMPLOYER'S ADDRESS _____

REFERRED BY DR. _____

Have you ever been treated in our office before? YES NO

IF SO, WHEN? _____

IN CASE OF EMERGENCY, NOTIFY _____

PHONE NO. _____ RELATIONSHIP _____

FINANCIALLY RESPONSIBLE PERSON IF OTHER THAN PATIENT

NAME (FIRST, M.I., LAST) _____

ADDRESS _____

CITY _____

STATE _____ ZIP _____

SEX: MALE FEMALE

DATE OF BIRTH _____ SOCIAL SECURITY NO. _____

HOME PHONE NO. _____ WORK PHONE NO. _____

OCCUPATION _____

EMPLOYER _____

ADDRESS _____

CITY _____

ST _____ ZIP _____

PATIENT'S EMAIL ADDRESS _____

CHART NO. _____

DOCTOR _____

REF. DOCTOR _____

Please complete both sides of this form.

PRIMARY DENTAL INSURANCE

NAME OF INSURANCE CO. _____

PHONE NO. _____

ADDRESS _____

CITY _____ ST _____ ZIP _____

ID/AGREEMENT NO. _____ GROUP NAME OR NO. _____

SUBSCRIBER'S NAME ON INSURANCE COVERAGE (if different from patient) _____

DATE OF BIRTH _____ SOCIAL SECURITY NO. _____

EMPLOYER'S NAME _____

ADDRESS _____

HOW IS PATIENT RELATED TO THE SUBSCRIBER?
 SPOUSE DEPENDENT

DATE _____

SECONDARY DENTAL INSURANCE

NAME OF INSURANCE CO. _____

PHONE NO. _____

ADDRESS _____

CITY _____ ST _____ ZIP _____

ID/AGREEMENT NO. _____ GROUP NAME OR NO. _____

SUBSCRIBER'S NAME ON INSURANCE COVERAGE (if different from patient) _____

DATE OF BIRTH _____ SOCIAL SECURITY NO. _____

EMPLOYER'S NAME _____

ADDRESS _____

HOW IS PATIENT RELATED TO THE SUBSCRIBER?
 SPOUSE DEPENDENT

What percentage will this Insurance Co. cover? _____ %

Signature _____

Fill out information to the left ONLY if you have dental insurance

PATIENT'S NAME (please print)

1. General Health:

Excellent Good Fair Poor

2. Are you under the care of a physician?

Yes No

If yes, please explain: _____

3. Name and address of family physician:

4. Are you wearing a pacemaker or heart valve prosthesis?

Yes No

5. Have you been hospitalized or had a serious illness in the past five years?

Yes No

If yes, please explain: _____

6. Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma?

Yes No

7. Are you taking *any* kind of medication (prescribed or non-prescribed) or drug at this time?

Yes No

If yes, please explain: _____

8. Are you pregnant?

Yes No

If yes, how many months? _____

9. Have you ever undergone Endodontic Treatment?

Yes No

Check any of the following to which you're allergic or have had an unusual reaction to:

Penicillin

Aspirin

Demerol

Sulfa Drugs

Darvon

Nitrous Oxide

Erythromycin

Codeine

Steroids

Novacaine (Xylocaine)

Valium (tranquilizers)

Ibuprofen

Sedatives & Barbituates

Latex

Nickel

Other _____

Check any of the following which you have had:

HIV+

Sinus Trouble

Glaucoma

Hepatitis

Anemia

Thyroid Trouble

Heart Trouble

Asthma

Fainting Spells

Heart Murmur

Cough

Venereal Disease

Rheumatic Fever

Hay Fever

Herpes

High Blood Pressure

Hives or Skin Rash

Arthritis

Angina

Diabetes

Kidney Trouble

Stroke

Tuberculosis

Radiation Therapy

Congenital Heart Disease

Epilepsy

Psychiatric treatment

Ulcers or Lung Disease

Migraine

Is there anything else about your health we should know? _____

What is your chief dental complaint? _____

Signature _____ Date _____