

Patient's Name		Today's date:	
Preferred Name	Male    Female	SS#	
Address		Age	Birth Date:
City/State/Zip		Home Phone:	
Who referred you?		School	
General Dentist		Office Phone	
Approximate date of last dental visit:		For what service?	

**RESPONSIBLE PARTY INFORMATION**

Name		E-mail:	
Address		How long at this address	
Previous Address (if less than 3 years)			
Home Phone		Cell Phone	Work Phone
SS#	DOB	Relationship to Patient	
Employer		No. Years Employed	
Spouse's Name		DOB	
Work Phone		Cell Phone	SSN#
Employer		No. Years Employed	

**INSURANCE INFORMATION**

Insured's Name		DOB	SS#
Insurance Company		Group#	
Insurance Company Address			
Do you have secondary insurance coverage? YES _____ NO _____ If YES, please continue...			
Insured's Name		DOB	SS#
Insurance Company		Group#	
Insurance Company Address			
Insured's Employer			

**EMERGENCY INFORMATION**

Name of nearest relative not living with you	
Address	
City/State/Zip	
Phone	Relationship to Patient
I understand that where appropriate, credit bureau reports may be obtained.	
Signature	Date

**HEALTH HISTORY**

Physician

Phone#

List any allergies

Circle any that apply:

Anemia	Convulsions	Hearing	Malignancies
Asthma	Diabetes	Heart	Mononucleosis
Bleeding Disorders	Fainting	Hepatitis	Mitral Valve Prolapse
Canker Sores	HIV+	Intestinal	Oral Herpes
Chronic Sinus	Headaches	Kidney	

Any history or conditions not listed above

I have read and understand the Notice of Privacy Practices

I understand that photographs may be used for advertising or any lawful purpose.

Broken appointments without 24 hour advance cancellation notice  
will be assessed a \$25 fee.

Signature

Date

**OFFICE USE ONLY**