PERSONAL AND HEALTH INFORMATION (CONFIDENTIAL)

Patient Information (Please Print)

Patient's Name _____ (NICK NAME) Sex M F Birthdate ___/___/___ (MO DAY YR.) Age _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Email: _____

Employer _____ Occupation _____ How Long _____

Marital Status _____ Spouses Name _____

Spouses Employer _____ Spouses Work # _____ Spouses Cell # _____

Name of Physician _____

Whom may we thank for referring you to us? _____

TO OUR NEW PATIENTS

The questions contained in this questionnaire all have a direct bearing on your health and may be significant in providing treatment for you comfortably and safely; therefore, it is important that you answer the following questions. Please remember the answers to the questions will be held confidential.

Yes No Are you under any medical treatment now?
Yes No Have you had any serious illness or operation?
Yes No Are you taking any drugs or medication?
Yes No Women - Are you pregnant?

Do you have or have you had any of the following? Please check:

- ❒ Rheumatic Fever
- ❒ Heart Murmur
- ❒ Mitral Value Prolapse
- ❒ High or Low Blood Pressure
- ❒ Anemia
- ❒ Blood Disorder
- ❒ Bleeding Problems
- ❒ Diabetes
- ❒ Herpes
- ❒ Aids / HIV Positive
- ❒ Joint Replacement
- ❒ Kidney Trouble
- ❒ Hepatitis, Jaundice or Liver Disease
- ❒ Tuberculosis or Venereal Disease
- ❒ Convulsions or Epilepsy
- ❒ Tumors or Growths
- ❒ Allergies
- ❒ Dizziness or Fainting
- ❒ Asthma, Hayfever or Sinusitis
- ❒ Latex Allergies

Medications currently being taken by patient:

Doctor's comments:

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

We shall endeavor to make your visits as convenient and pleasant as possible. If at any time you have any questions regarding your treatment, appointment or fees, please feel free to ask. In order to minimize bookkeeping time and therefore eliminate unnecessary fee increases, all fees for professional services will be paid at time of treatment or billed through VISA, Master Card or Discover if eligible. If unable to keep a scheduled appointment, please give at least 24 hours notice. We reserve the right to charge for broken or canceled appointments without 24 hours notice.

X _____

SIGNATURE OF PATIENT (Or parent if a minor) DATE