Today's Date ____/____/____

Name _____/_____/_____ Sex: M F
First M.I. Last

Mailing Address: _____

E-Mail Address: _____ Marital Status: S M W D

D.O.B. ____/____/____ SSN# ____/____/____ Home # ( ) _____ Work # ( ) _____

Place of Employment: _____ Occupation: _____ Cell # ( ) _____

Insurance: _____ Group #: _____ Employee ID# _____

Person to contact in case of emergency: _____ Phone # _____

Spouse or Parent Name: _____ Work # ( ) _____ Ext: _____

Spouse or Parent Employment: _____ Occupation: _____

Referred By: _____

ARE YOU ALLERGIC TO:

Aspirin	Yes	No	Local Anesthetics	Yes	No	Other: _____
Codeine	Yes	No	Penicillin	Yes	No	_____
Latex	Yes	No	Sulfa Drugs	Yes	No	_____

Please list ANTIBIOTICS you are ALLERGIC to: _____

Are you taking BISPHOSPHONATES (Medication for OSTEOPOROSIS)? Yes No

Have you ever been treated or diagnosed as having: (Circle YES or NO)

Anemia/Blood Disorder	Yes	No	Glaucoma	Yes	No
Alzheimer's Disease	Yes	No	Heart Disease/Surgery	Yes	No
Asthma	Yes	No	Heart Attack/Failure	Yes	No
Angina	Yes	No	Heart Murmur	Yes	No
Arthritis/Gout	Yes	No	Pace Maker/Defibrillator	Yes	No
Artificial Heart Valve	Yes	No	Hemophilia	Yes	No
Blood Disease	Yes	No	Hepatitis A	Yes	No
Chronic Obstructive	Yes	No	Hepatitis B or C	Yes	No
Pulmonary Disease (COPD)	Yes	No	Irregular Heart Beat	Yes	No
Cancer			Herpes Virus	Yes	No
Chemotherapy/Radiation	Yes	No	High Blood Pressure	Yes	No
Cold Sores/Fever Blisters	Yes	No	HIV/AIDS	Yes	No
Congential Heart Disorder	Yes	No	Total Joint Replacement	Yes	No
Currently Pregnant	Yes	No	Liver Disease	Yes	No
Depression	Yes	No	Lung Disease/TB	Yes	No
Diabetes	Yes	No	Low Blood Pressure	Yes	No
Emphysema	Yes	No	Migraine Headaches	Yes	No
Epilepsy/Seizures	Yes	No	Mitral Valve Prolapse	Yes	No
Excessive Bleeding	Yes	No	Neck/Head Pain	Yes	No
Fainting/Nervous	Yes	No	Rheumatic Fever	Yes	No
Frequent Cough	Yes	No	Sinus Problems	Yes	No
Stroke	Yes	No	TMJ/Clicking Jaw Joint	Yes	No
Thyroid Disease	Yes	No	Tobacco User	Yes	No
Ulcers	Yes	No	Venereal Disease	Yes	No

NAME OF MEDICATIONS PRESENTLY TAKING: _____

_____

Do you need to pre-medicate before dental treatment? YES NO Do you use a CPAP Machine? YES NO

Explain: _____

Name of Physician _____ Physician's Address _____

All new patients will pay for any treatment provided on first visit: Cash, Check, Visa, MasterCard, Discover or American Express. As a courtesy to our patients, we will file primary insurance after deductible and co-pay have been met. Any secondary insurance can be filed only as reinbursement to the patient and not accepted as payment for treatment. Any balance NOT paid by primary insurance is the patient's responsibility.

_____ Date: _____

SIGNATURE OF PATIENT (IF UNDER 18 A PARENT OR GUARDIAN'S SIGNATURE