Marital Status	Male	
Male	Male   Female   Marital Status   Birth Date:   Car   Car	Date:
Social Security #:	Social Security #:	
Phone (Home):	Phone (Home):	
Can you accept texts	Best time/number to call: email	ID:
Street	Address:    Street   City   State	n you accept texts □ Y □ N
City   Referral Information	City   Referral Information	
City   Referral Information	City Referral Information  Whom may we thank for referring you to our practice? □Another patient (name) □ Dental Office (name) □ Yellow Pages □ Other_  Responsible Party Information  Name: □ Male □ Female	A
Referral Information  Whom may we thank for referring you to our practice?	Referral Information  Whom may we thank for referring you to our practice? □Another patient (name) □ Dental Office (name) □ Yellow Pages □ Other_  Responsible Party Information  Name: □ Male □ Female	<u> </u>
Whom may we thank for referring you to our practice?	Whom may we thank for referring you to our practice?	Zip Code
	Dental Office (name)	
Responsible Party Information  Name:	Responsible Party Information  Name: Male	
Name	Name:	
Name	Name:    DMale   Female   Marital Status	
Social Security #:	Social Security #:	
Social Security #:	Social Security #:	
Phone (Home): (Work): Ext: Best time to call:	Phone (Home):	
Address:	Street   S	
Street   S	Employer Name: Occupation:	t time to can.
Employer Name:Occupation:	Employer Name:Occupation:	Apartment #
City   State   Zip Code   Primary   Name of Insured:	Employer Name:Occupation:	Zip Code
City   State   Zip Code   Primary   Name of Insured:	Employer Name:Occupation:	
Street   City   State   Zip Code	Address:	
Insurance Information  Primary Name of Insured:  Last First MI Insured's Birth Date:  Insured's Address:  Street City State Zip Code  City State Zip Code  Insured's Address:  Patient's relationship to insured:  Insurance Plan Name and Address:  Secondary Name of Insured:  Secondary Name of Insured:  Last First MI Insured's Address:  Street City State Zip Code  City State Zip Code  Insurance Plan Name and Address:  Secondary Name of Insured:  Is insured a patient? □ Yes □ No Insured's Birth Date:  Ins	Insurance Information  Primary Name of Insured:	
Primary Name of Insured:  Last First MI Insured's Birth Date: Insured's Address: Insured's Employer Name:  Address:  Patient's relationship to insured: Insurance Plan Name and Address:  Secondary Name of Insured:  Last First MI Is insured a patient? □ Yes □ No  Insured's Birth Date:  Insured's Birth Date: Insured a patient? □ Yes □ No	Primary Name of Insured:	State Zip Code
Name of Insured:	Name of Insured:	
Insured's Birth Date:   D#:   Group #:   Insured's Address:   Insured's Employer Name:   Address:   Patient's relationship to insured:   Self   Spouse   Child   Other   Insurance Plan Name and Address:   Secondary   Name of Insured:   Is insured a patient?   Yes   No   Insured's Birth Date:   Insured's Bi	Insured's Birth Date: ID #: Group Insured's Address: Street City Insured's Employer Name: Street City Patient's relationship to insured: □ Self □ Spouse □ Child □ Other Insurance Plan Name and Address: Is in Insured's Birth Date: ID #: Group Insured's Address: ID #: Group Insured's Employer Name:	neurad a nationt? IT Yes IT No
Insured's Address:    Street   City   State   Zip Code	Insured's Address:  Street  Insured's Employer Name:  Address:  Patient's relationship to insured: □ Self □ Spouse □ Child □ Other  Insurance Plan Name and Address:  Secondary Name of Insured:  Last  Insured's Birth Date:  Insured's Address:  Insured's Employer Name:  Street  Street  City  City  City  City  City  City  City  City	·
Insured's Employer Name:  Address:  Patient's relationship to insured:   Secondary Name of Insured:  Last  Insured's Birth Date:  Street  Street  City State  Zip Code  Child Other  Is insured a patient?   Yes  No  First MI  Group #:	Insured's Employer Name:  Address:  Street  Patient's relationship to insured: □ Self □ Spouse □ Child □ Other  Insurance Plan Name and Address:  Secondary  Name of Insured:  Insured's Birth Date:  Insured's Address:  Insured's Employer Name:  Street  Insured's Employer Name:	p #:
Insured's Employer Name:  Address:  Patient's relationship to insured:   Secondary Name of Insured:  Last  Insured's Birth Date:  Street  Street  City State  Zip Code  Child Other  Is insured a patient?   Yes  No  First MI  Group #:	Insured's Employer Name:	
Patient's relationship to insured:  Secondary Name of Insured:  Secondary Insured's Birth Date:  Insured Birth Date:	Patient's relationship to insured:   Insurance Plan Name and Address:  Secondary Name of Insured:  Insured's Birth Date:  Insured's Address:  Insured's Employer Name:  Secondary  Insured's Pirst  Insured's Address:  City	
Patient's relationship to insured:  Secondary Name of Insured:  Secondary Insured's Birth Date:  Insured Birth Date:	Patient's relationship to insured:   Insurance Plan Name and Address:  Secondary Name of Insured:   Last Insured's Birth Date:  Insured's Address:   Insured's Employer Name:   Insured's Employer Name:   Insured's Pirst Insured's Pirst Insured's City	
Secondary Name of Insured:  Last First MI Insured's Birth Date:  ID #:  Group #:	Secondary Name of Insured:  Last Insured's Birth Date: Insured's Address: Insured's Employer Name:  Is in  First MI ID #: Group  City	
Name of Insured: Is insured a patient? □ Yes □ No Insured's Birth Date: ID #: Group #:	Name of Insured: Is in Insured's Birth Date: ID #: Group Insured's Address: City  Insured's Employer Name: City	
Name of Insured: Is insured a patient? □ Yes □ No Insured's Birth Date: ID #: Group #:	Name of Insured: Is in Insured's Birth Date: ID #: Group Insured's Address: City  Insured's Employer Name: City	
Insured's Birth Date: ID #: Group #:	Insured's Birth Date: ID #: Group Insured's Address: City Insured's Employer Name:	nsured a patient? ☐ Yes ☐ No
	Insured's Address:  Street  Insured's Employer Name:	n #:
Insured's Address:	Insured's Employer Name:	
Insured's Employer Name:	Address:	State Zip Code
Address:		
Street City State Zip Code  Patient's relationship to insured:   Self Spouse Child Other	Patient's relationship to insured:   Self  Spouse  City  City  City  City  City  City  City  Patient's relationship to insured:  Self  Spouse  Child  Other	
I dilotto totalionip to modios. — oc — oposto — ot — out	Insurance Plan Name and Address:	

## **Patient Information**

Patient Name:		Γ	Date:		
Last,	First	First MI (Preferred Name)			
DOD.					
DOB:					
Health Information					
incartii iiiitti iiiatitti					
Date of Last Dental Visit	Why a	re you here today?			
Have you ever had any of	the following? Please cho	ook those that apply:			
	the following. Thease en	eck those that apply.			
□ AIDS/HIV	☐ Fainting	□ Pacemaker	□ Codeine Allergy		
□ Allergies	□ Glaucoma	□ Pregnancy	□ Penicillin Allergy		
□ Aspirin Therapy	□ Growths	Due date:	□ Keflex Allergy		
□ Anemia	□ Hay Fever	□ Radiation Treatment	☐ Latex Allergy		
□ Arthritis	☐ Head Injuries	□ Respiratory Problems	☐ Osteoporosis Therapy		
□ Artificial Joints	☐ Heart Disease	☐ Rheumatic Fever	□ Chemotherapy		
□ Artificial Valves	□ Heart Murmur	□ Rheumatism	☐ Birth Control		
□ Asthma	□ Hepatitis	☐ Sinus Problems	☐ Mitral Valve Prolapse		
□ Blood Disease	☐ High Blood Pressure	☐ Stomach Problems	□ Alzheimer's Disease		
□ Cancer	□ Jaundice	□ Stroke	□ Tobacco use		
□ Diabetes	□ Kidney Disease	□ Tuberculosis	How much:		
□ Dizziness	☐ Liver Disease	□ Tumors	How long:		
□ Epilepsy	☐ Mental Disorders	□ Ulcers	☐ Other ☐ No to all the above		
☐ Excessive Bleeding	□ Nervous Disorders	□ Venereal Disease	□ No to all the above		
• List current medications:	Tell trul species to 1	Employeignt In			
<ul> <li>Allergies to Medications,</li> </ul>	Novocaine, other:				
	omplications following dent		- Hotel and		
		rgency care during the past tw	vo years? Yes No		
	are of a physician? Yes	No	AND THE PROPERTY OF THE PROPER		
Name of Physician:		Ph	none:		
	roblems that need further c	larification? Yes No	g specific		
		wers and information provided octors at the next appointmen			
			Date:		
Signature of patient, paren	nt or guardian				