WELCOME TO OUR OFFICE

Name____ Date Of Birth__________________
First M.I. Last Month Day Year

Name I Would Like Staff To Call Me___________________ Marital Status_________________
s, m, w, d, sep

Home Address____
Street City State Zip Apt. no.

Home Phone_________________ Bus. Phone_______________ Soc. Sec. No.______________

Employed By_________________________________ Present Position____________________

Business Address____

Name of Spouse or Parent______________________________ Home Phone________________
(of minor child)

Spouse/Parent Employed By___________________________ Present Position______________

Business Address____ Bus. Phone_____________

Person Responsible For This Account____

Do You Have Dental Insurance? ______ Policy No._____________ Group No._____________

Name Of Ins. Co.__________ Name & SSN of Policy Holder ___________________________

Do You Have Any Other Dental Insurance Coverage?___________________________________

Who May We Thank For Referring You To Our Office?_________________________________

I understand that payment is expected at the time of service unless prior arrangements have been made. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. I understand that there is a charge of $50- per half hour for appointments cancelled or broken with less than 24 hours notice. I am aware that I am responsible for any collection and/or legal fees incurred should this account become delinquent.

Today's visit will be paid by: Cash_____ Check_____ Visa/MC/AMEX/Discover_____

Signature____ Date__________________

Health History

	Yes	No
1. Are you under the care of a doctor for anything?	____	____
2. Have you been a patient in a hospital lately?	____	____
3. Are you currently taking any drugs or medicines?	____	____
4. Are you allergic to penicillin or any drugs, medicines or metals?	____	____
5. Do you have any bleeding problems that require special treatment?	____	____
6. (Women) Are you pregnant?	____	____
7. Do you use tobacco products (smoke, snuff or chew)?	____	____

8. Please circle any of the following which you have now or have had in the past

High Blood pressure	Arthritis	Stroke
Cancer	Jaundice	Epilepsy
Venereal Disease	Hepatitis	Herpes
Tuberculosis	AIDS	HIV Positive
Rheumatic Fever	Heart Murmur	Asthma
Glaucoma	Heart Trouble	Diabetes

9. Have you had any other medical conditions that we should know about?________________________________

10. What is the name and address of your physician?________________________________

11. What is your reason for visiting our office today?________________________________

12. Are you having any dental problems?________________________________

13. Who was your previous dentist?________________________________

14. When was your last dental appointment? ________________________________

15. Are you unhappy with the way your teeth look when you smile? ________________________________

16. Who should we contact in case of emergency? ________________________________
name phone

Signature____________________________ Date____________________