Date____________

Patient Information

In order for our office to provide proper periodontal services for you, please complete the following questions in their entirety. All information is kept strictly confidential. Thank you.

Patient Name____

Social Security#_______________________Date of Birth______________Sex____M____F

Mailing Address____

City____State__________Zip____________

Home Phone#________________________Cell Phone#______________________

Referring Dentist Name____

Employer__________________________________Occupation________________

Address____

Work Phone#________________________

Primary Dental Insurance - Please indicate: Self, Spouse, or Parent________________

Policyholder Name______________________________SS/ID#__________________

Insurance Co. Name_____________________________Group#__________________

Insurance Co. Address____

Insurance Co. Phone#_____________________________

Spouse/Parent Name:____

Social Security#_______________________Date of Birth______________Sex____M____F

Employer____Occupation______________

Work Address____________________________________Work Ph#______________

Secondary Dental Insurance - Policyholder Name________________________________

SS/ID# ________________________________Date of Birth____________________

Insurance Co. Name_____________________________Group#__________________

Insurance Co. Address____

Insurance Co. Phone#_____________________________

Health History

When did you last have your teeth cleaned?____

Are you currently under the care of a doctor? Y_______N_______ If so, for what?_______________

____

Have you had any health problems in the last 5 years? Please list__________________________

____

Current medications: (Include over-the-counter meds and vitamins)___________________________

____

____

Are you allergic or sensitive to any of the following?

Penicillin Y________N________

Novocain Y________N________

Codeine Y________N________

Latex (Gloves) Y________N________

Aspirin Y________N________

Please list any others____

Do you or have you had any of the following:

Rheumatic fever.. Y__________N__________

Stroke.. Y__________N__________

High blood pressure.. Y__________N__________

Heart Murmur.. Y__________N__________

Mitral Valve Prolapse.. Y__________N__________

Anemia.. Y__________N__________

Asthma.. Y__________N__________

Diabetes.. Y__________N__________

Positive test for AIDS/HIV.. Y__________N__________

Positive Test for Venereal disease/STD.. Y__________N__________

Abnormal bleeding.. Y__________N__________

Epilepsy.. Y__________N__________

Orthopedic joint replacement.. Y__________N__________

Organ transplant.. Y__________N__________

Radiation treatment for a tumor or growth.. Y__________N__________

Smoker: Date that you quit____________.. Y__________N__________

Women: Are you pregnant? Due date____________.. Y__________N__________

Tuberculosis.. Y__________N__________

Hepatitis/liver disease: A___B___C___.. Y__________N__________

Thyroid.. Y__________N__________

Do you get out of breath easily?.. Y__________N__________

List any other health condition/problem we should be aware of____________________

____

Name of your physician____

I authorize the release of information related to this claim and authorize payment to the dentist of the group insurance benefits otherwise payable to me. I understand I am responsible for all costs of the dental treatment.

**Signed____Date_________________________