PATIENT HEALTH AND HISTORY

TO ENABLE US TO RENDER THE BEST POSSIBLE TREATMENT, PLEASE FILL OUT THIS FORM COMPLETELY.

Patient Information:

Name:_____
Last First Middle Male or Female
Birth Date: _____Social Security#: _____ E-mail:_____

Home Address: _____Phone#: _____Cell#_____
Street Address City, St Zip
Previous Address, If Less Than 1 Yr @ Present Address: _____

Mailing Address: _____

Employer: _____ Position: _____ Department: _____

Employer Address: _____Work Phone#: _____

Is Patient A Student: _____ If Yes, Full Time Or Part Time:_____ School: _____

Does Patient Have Dental Insurance:_____ Yes _____ No Name Of Insurance: _____

Policy Holders Name:_____Birthdate:_____ID#:_____

Person responsible for this Acct: _____

Purpose of visit: _____

Family Information:

Spouse/Guardian: _____
Last First Middle
Home Address: _____Phone#: _____

Birthdate _____SSN#:_____ Driver License#: _____

Employer: _____ Employer Address: _____ Work #: _____

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

Names of other family members treated in this office:_____
_____

Has the patient ever experienced any unfavorable reaction from any previous dental treatment? _____Y/N_____

If yes, please explain: _____

Is there any reason why x-rays should not be taken? _____ Yes/No_____
If yes, please explain: _____

Woman: are you pregnant? _____yes _____no

By signing your name to this document, you agree to accept financial responsibility for any dental services provided and acknowledge that you understand our office policy is to charge 1.5% interest per month on all unpaid balances, plus any court cost, and retrieval of your credit report when necessary.
I hereby authorize treatment and use of nitrous oxide, anesthesia, oral sedation and, or other meds necessary.

Patient/Guardian signature: _____**Date**_____