PATIENT INFORMATION

Name _____

Birthday_____Age_____ Sex_____M_____F

Address _____

City_____Zip_____

Home Phone_____SS# _____

Cell_____Email _____

How would you like to be contacted/reminded? _____

Primary Care Physician _____

Employer_____Work Phone _____

Do you have dental insurance: _____Yes _____No

Insurer _____

Name of Insured Employee _____

Date of Birth and SS# of Insured _____

Have you had any surgeries or illnesses in the last 2 years? Yes/No

(If yes, please explain) _____

_____

Are you taking any drugs or medicine? Yes/No

(Please List) _____

_____

Do you have any allergies to ANYTHING? Yes/No

(Drugs, dental anesthetics, penicillin, etc. - Please List)

_____

(Check) Are you being treated for any of the following?

___ Arthritis	___ Fainting spells	___ Mitral Valve Prolapse with regurgitation
___ Artificial Joint	___ Fibromyalgia	___ Multiple Sclerosis
___ Asthma	___ Glaucoma	___ Pregnant
___ Bleeding Problem	___ Heart Valve Replacement	___ Severe headaches
___ Blood disease	___ Hepatitis A, B, or C	___ Sinus trouble
___ Cancer	___ High Blood Pressure	___ Stroke
___ Cigarette or Tobacco use	___ High Cholesterol	___ Thyroid disease
___ Circulatory problem	___ HIV/AIDS	___ Tuberculosis
___ Cortisone or Steroid treatment	___ Kidney disease	___ Venereal disease
___ Diabetes	___ Liver disease	

Indicate any disease, condition, or problem not listed _____

Remarks: _____

_____

_____

PERMISSION FOR TREATMENT AND PROMISE OF PAYMENT

This is to certify that I, the undersigned, consent to the performance of any and all procedures, and the use of any and all drugs that are agreed to be necessary or advisable. I also agree to accept full responsibility for the payment of all fees associated with those procedures or drugs and all reasonable attorney fees incurred in the collection of those fees.

Signature (Parent) _____

Date _____