WELCOME

PATIENT INFORMATION:

NAME:________________ BIRTHDATE:__________ AGE:____ SEX: M / F

ADDRESS:________________ CITY:________ STATE:______ ZIP:______

☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED SS#:________________

HOME PHONE:________________ CELL PHONE:________________

E-MAIL ADDRESS:________________________________

EMPLOYER:____________ OCCUPATION:____________ BUSINESS PHONE:____________

WHOM MAY WE THANK FOR REFERRING YOU? ________________________

IN CASE OF AN EMERGENCY NOTIFY:________________ PHONE:____________

INSURANCE INFORMATION:

PERSON RESPONSIBLE FOR ACCOUNT:________________________

RELATIONSHIP TO PATIENT:____________ BIRTHDATE:__________ SS#:____________

ADDRESS IF DIFFERENT FROM ABOVE:________________ PHONE:____________

CITY:________________ STATE:__________ ZIP:____________

INSURANCE CO:________________ PHONE:________________

GROUP/POLICY #:____________ SUBSCRIBER ID#__________

Medical History Update -- Please Do Not Complete This Section Unless Instructed

Have there been any changes in your health since your last dental appointment? Yes No

For what conditions? ________________________

Have you had any serious illnesses or operations? Yes No

Are you taking any new medications? ________ If so, what?________________

________________________ ________________

Signature Date

Have there been any changes in your health since your last dental appointment? Yes No

For what conditions? ________________________

Have you had any serious illnesses or operations? Yes No

Are you taking any new medications? ________ If so, what?________________

________________________ ________________

Signature Date