

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