Welcome

Patient Information

Patient's Name ______________________ Age __________ Birth Date __________

Nickname (if preferred) ______________ Male Female

Home Phone ______________ Cell Phone ______________ SS # ______________

Home Address ______________________ City, State, ZIP ______________________

Employer ______________________ Employer's Address ______________________

Occupation ______________________ How Long? __________

General Dentist ______________________ Who referred you to our office?______________

Have we treated another member of your family? YES NO If YES, Name ______________

Dental and Medical History

Are you currently under the care of a physician? YES NO If YES, for what reason? ______________

Physician ______________________________ Phone # ______________

History of major illness? YES NO If YES, please describe ______________________

Any sensitivities or allergies? YES NO If YES, please list ______________ Amount/Dose ________

Currently taking any medications? YES NO If YES, please list ______________ Amount/Dose________

Are you or could you be pregnant? YES NO

Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

I hereby authorize release of any information to my referring doctor.

Signature ______________________________ Date ______________________