Chart #

Patient Name: _____Preferred Name_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date:_____Age:_____

Phone--- Home: _____ Work: _____ Cell: _____

Address_____
Street City State Zip Code

E-Mail Address_____

Employer_____

Employer's address_____
Street City State Zip Code

Do you have dental insurance? yes_____ no_____

Date of your last dental visit: _____Reason for your visit today:_____

Have you ever had any of the following? Please check those that apply:

☐ **Allergies** _____
_____
☐ **Anemia**
☐ Arthritis/Rheumatism
☐ Artificial Joints
☐ Asthma
☐ **Blood Disease**
☐ Cancer
☐ **Diabetes**
☐ Dizziness/Fainting
☐ Epilepsy
☐ Excessive Bleeding
☐ Glaucoma
☐ Hay Fever
☐ **Heart Disease**
☐ Heart Murmur
☐ **Hepatitis**
☐ **High Blood Pressure**
☐ **Kidney Disease**
☐ **Liver Disease**
☐ Mental/Nervous Disorders
☐ have **a Pacemaker**
☐ **Pregnant**
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Sinus Problems
☐ Stomach Problems
☐ **Stroke**
☐ **Tuberculosis**
☐ Tumors/Growths
☐ VD / STD / AIDS
☐ Swollen gums
☐ Bleeding gums
☐ Loose teeth
☐ Bad breath
☐ Other

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No If yes, please explain:
-_____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain:_____

- Are you taking any medications or herbal supplements? ☐ Yes ☐ No
If yes, please list: _____

- Name of your Physician: _____ City:_____

- Do you have any other health problems that we need to know about? ☐ Yes ☐ No If yes, please explain:
_____

To the best of my knowledge, all of the information provided is true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____

Signature of patient, parent or guardian

Spouse or Responsible Party Information:

Name: _____ Date of birth:_____

Address _____ State: _____ Zip Code: _____

Home phone: _____ Cell phone: _____ Work: _____

Insurance Information:

Primary subscriber: _____ Date of birth: _____

Insurance company: _____ ID#: _____

Employer's name: _____

Secondary subscriber: _____ Date of birth: _____

Insurance company: _____ ID#: _____

Employer's name: _____

I agree to be responsible for all charges for dental services and materials not paid by my dental plan.

_____

Signature