

First Name	MI	La	st Name	
Gender	Date of Birth		Preferred Name	
Mailing Address			City	
State Zip Co	ode	SSN		
Email Address			Home Phone	
Work Phone		Other Nu	umber	
Employer		Occupati	on	
Spouse	Spouses'	DOB	Spouse's SSN	
Spouse's Employer		Spouse's l	Phone	
Referred By				
How Did you Hear About Us	?			
Parent/Guardian Name (if par	tient is a minor)			
Second Parent/Guardian Na	me			
DENTAL INSURANCE	INFORMATION			
Primary Coverage Insurance Company				
Insured's Name				
Insured's Employer				
Insured's SSN Insured's DOB				
Group #				
Secondary Coverage				
,				
Insured's Name				
Insured's Employer				
Insured's SSN		Insured's	DOB	
Group #				



MEDICAL HISTORY

Allergy to Nickel Angina (Chest Pains) Anemia Arthritis (Osteo or Rheumatoid) Artificial Heart Valve Artificial Joint (Knee, Hope or Other) When? Ashma Blood Thinner Which One? Cancer/Radiation Treatment Chemical Dependence Circulatory Problems Diabetes Controlled Dizziness/Fainting Epilepsy GERD Glaucoma Head Injury Heart Murmur or Mitral Valve Prolapse Hepatitis HIV High Blo High Che Anter Hall Plove Latex All Hold Heat All HIV High Blo High Che Anter Hall Plove Latex All Hold Heat Migh Che Latex All Hold Hold Hold Hold Hold Hold Hold Ho	ood Pressure olesterol Disease
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Head Injury Ulcer Other ite	S
Ulcer Heart Murmur or Mitral Valve Prolapse Other ite	losis
Other ite	
Hepatitis	ems not listed
Do you currently need an antibiotic prior to your dental appointment?	
Do you use Tobacco? (Chew, Smoke or Other) Are you cui	
Medication(s)	
Allergies	rrently pregnant?

Signature ____