

PATIENT INFORMATION

Home Address	Name (Mr., Mrs., Miss) First	MI	Last			
Home Phone				Apt#		
Cell Phone	City		State	Zip	·	
Date of Birth	Home Phone		Work Phone			
Date of Birth	Cell Phone		Employer			
INSURANCE INFORMATION Primary Insurance Group No. Subscriber I.D. No. Relationship to Patient Group No. Subscriber I.D. No. Relationship to Patient Date of Birth Secondary Insurance Group No. Subscriber I.D. No. Relationship to Patient Date of Birth HEALTH HISTORY YES Have you been treated by a physician during the last two years? If yes, explain Are you taking any medications at present? If yes, please list Are you allergic or sensitive to penicillin, Novocaine, Codeine, Latex or any other medications? Please list Have you ever had unfavorable reaction after dental treatment? Do you require antibiotic pre-medication before dental treatment? Have you ever had any of the following illnesses? (please circle) Rheumatic Fever Nervous disorders Fainting Kidney disease High blood pressure Hepatitis Tumors Stroke Joint replacement Tumors Stroke Joint replacement Tumors Stroke Heart valve replacement Tumors Stroke Joint replacement Tumors Stroke Heart trouble Excessive Bleeding Any other information about your health condition that should be known?						
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Subscriber	(if patient is a minor) Name of F	arent				·
Subscriber		SURANCE IN	IFORMATION			
Subscriber	Primary Insurance Group No.					
Relationship to Patient						
Secondary Insurance Group No. Subscriber I.D. No. Relationship to Patient Date of Birth HEALTH HISTORY YES Have you been treated by a physician during the last two years? If yes, explain Are you taking any medications at present? If yes, please list Are you allergic or sensitive to penicillin, Novocaine, Codeine, Latex or any other medications? Please list Have you ever had unfavorable reaction after dental treatment? Female patients, are you pregnant? Which month? Do you require antibiotic pre-medication before dental treatment? Have you ever had any of the following illnesses? (please circle) Rheumatic Fever Nervous disorders Fainting Kidney disease High blood pressure Hepatitis Epilepsy Heart valve replacement Tumors Stroke Joint replacement Tuberculosis Asthma Heart pacemaker Venereal disease Diabetes HIV/AIDS Heart trouble Excessive Bleeding Any other information about your health condition that should be known?						
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Potiont/Perent's Signature	Patient/Parent's Signature			Date		