PATIENT AND INSURANCE INFORMATION (GENERAL)

Mr.
Mrs.
Miss.
Ms. _____
FIRST MIDDLE LAST

BIRTHDATE: _____ ~~SOCIAL INSURANCE #~~ _____
DAY / MONTH / YEAR

If Child, Parent or Guardian's Name _____

ADDRESS: _____
APT # STREET or AVENUE CITY or TOWN

PROVINCE: _____ POSTAL CODE: _____

PHONE: _____ _____ _____
HOME WORK CELL PHONE

Emergency Contact: _____ Phone Number: _____

Previous Dentist's Name: _____ Phone Number: _____

DENTAL INSURANCE INFORMATION

Name of Insurance Company: _____

Group or Policy Number: _____

Personal ID Number: _____

Name of Insured Person: _____ Date of Birth: _____

Employer: _____

I, the undersigned (patient or legally responsible person) authorize dental treatment to be rendered by the Dentist and his staff. I accept complete financial responsibility for all treatment rendered and I understand that payment is required on the day of service. I also acknowledge that some dental treatments may not be covered by dental insurance.

SIGNATURE: _____ DATE: _____

Who may we thank for referring you to our office? _____

MEDICAL HISTORY

Personal Physician: _____ **Physician's phone #**_____

Have you ever had any of the following diseases or medical problems? Please circle the correct one(s):

Heart attack/ stroke	Asthma	Liver disease/problems
Heart murmur	Emphysema	Kidney disease/problems
Rheumatic Fever	Sinus problems	Stomach disorders/problems
Congenital heart disease	Lung problems	Artificial Bones/Joints/etc.
Congenital heart defects	Difficulty breathing	Cancer/ Chemotherapy
Mitral Valve Prolapse	Fainting spells	Radiation Therapy
Heart surgery/ Pacemaker	Epilepsy/ Seizures	Arthritis
Artificial heart valves	Ulcers/Colitis	Diabetes
High or Low Blood Pressure	Anemia	Venereal Disease
Blood Transfusion	Tuberculosis	HIV positive/ AIDS
Glaucoma	Jaundice	Hepatitis
Depression	Psychiatric treatment	Severe/Frequent headaches
Drug/alcohol abuse	Jaw Joint Pain	Are you pregnant Y or N
Abnormal Bleeding	Angina	Are you nursing Y or N

Please list any other medical condition(s) or serious illnesses that you have had:_____

_____

Have you ever been hospitalized for any reason? If so, please explain: _____

_____

Are you currently taking ANY medications, or have you taken ANY medications over the course of the past year. If so, please list them: _____

_____

_____

Are you allergic to any of the following? If so, please circle:

Penicillin	Ibuprofen(eg.Advil)	Tetracycline
Erythromycin	Dental Anesthetic	Codeine
Clindamycin	Aspirin	Acetaminophen(eg.Tylenol)
Latex	Septra/sulfa drugs	Other(please list):_____

Is there anything that you would like to change about your smile? If so, what would you like to change?_____

_____

** I understand that the information that I have given today is to the best of my knowledge and is correct . I also understand that this information will be held in strict confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental service with my informed consent that I may need during diagnosis and treatment.*

Patient's signature: _____**Dentist's Signature**_____ **Date**_____