PERSONAL INFORMATION:

NAME:_____
DOB:_____
SS#:_____
ADDRESS:_____
_____
CITY:_____ST:_____ZIP:_____
PHONE #:_____
CELL PHONE #:_____
SEX: MALE OR FEMALE (CIRLCE ONE)

INSURANCE INFORMATION:

CO. NAME:_____
ADDRESS:_____
_____
PHONE NUMBER:_____
INSURED'S ID:_____
INSURED'S NAME:_____
RELATION:_____DOB:_____
INSURED'S EMPLOYER:_____

EMERGENCY CONTACT:

NAME:_____
RELATION:_____
PHONE #:_____
ADDRESS:_____
_____

RESPONSIBLE ACCOUNT INFORMATION:

NAME:_____
BILLING ADDRESS:_____
_____
SS#:_____
DOB: _____DRIVERS LIC. #:_____
CELL#:_____
(IF INFORMATION IS DIFFERENT FROM PERSONAL PLEASE SPECIFY)

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING CONDITIONS? (Please Circle)

Y N HEART ATTACK	Y N THYROID PROBLEMS	Y N CANCER/TUMORS	Y N COSMETIC SURGERY
Y N HEART SURGERY	Y N KIDNEY PROBLEMS	Y N SHINGLES	Y N XRAY/COBALT TREATMENT
Y N HEART MURMUR	Y N LIVER PROBLEMS	Y N HEPATITIS	Y N CHEMOTHERAPY
Y N RHEUMATIC FEVER	Y N RESPIRATORY PROBLEMS	Y N HIV+/AIDS/ARC	Y N ASTHMA
Y N MVP	Y N SINUS PROBLEMS	Y N ARTHIRITS/RHEUMATISM	Y N DIFFICULTY BREATHING
Y N ARTIFICIAL VALVES	Y N STOMACH PROBLEMS	Y N ARTIFICIAL BONES/JOINTS	Y N DIABETES/HYPOGLYCEMIA
Y N HEART DISEASE	Y N PSYCHIATRIC PROBLEMS	Y N EMPHYSEMA	Y N LEUKEMIA
Y N HEART DEFECT	Y N VENEREAL DISEASE	Y N FAINTING/SEIZURES/EPILEPSY	Y N ANEMIA
Y N CHEST PAINS	Y N ALCOHOL/DRUG ABUSE	Y N SEVERE/FREQUENT HEADACHES	Y N HIGH/LOW BLOOD PRESSURE
Y N SCARLET FEVER	Y N TUBERCULOSIS TB	Y N FREQUENT NECK PAIN	Y N BLEEDING PROBLEMS
Y N NERVOUSNESS	Y N JAW PROBLEMS TMJ/TMD	Y N BACK PROBLEMS	Y N GLAUCOMA

PLEASE LIST ANY OTHER MEDICAL PROBLEMS: _____
ARE THERE ANY KNOW ALLERGIES: _____
ANYTHING DR. SHOULD KNOW ABOUT YOU? Y/N **EXPLAIN**:_____
PREVIOUS DENTIST NAME:_____PHONE #:_____

SIGNATURE: _____DATE:_____