WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out the form completely. We are happy to assist you with any questions and we look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

NAME…….
ADDRESS……...
HOME PHONE…….. WORK…… CELL ……..……
DATE OF BIRTH…… SEX……
INSURANCE……. OCCUPATION……...
PERSON RESPONSIBLE FOR ACCOUNT……..
E-MAIL ADDRESS……..…… …
EMERGENCY CONTACT: Name…..……. Telephone nos…..…….
WHOM SHOULD WE THANK FOR REFERRING YOU ☐ NAME OF PERSON……..……
☐ TELEPHONE DIRECTORY ☐ SIGN ☐ OTHER

Please check the box if you have or have had any of the following conditions.

☐ AIDS/HIV Positive
☐ Allergies (specify type)
☐ Anxiety/ Panic Attacks
☐ Artificial Joints
☐ Asthma
☐ Cancer
☐ Diabetes
☐ Easy bleeding or bruising
☐ Epilepsy, seizures or fainting
☐ Glaucoma
☐ Heart disease (chest pain, heart attack, angina, stroke
☐ Any other medical conditions not listed above? …….…….

☐ Heart murmur
☐ High blood pressure
☐ Hypo or hyperthyroidism
☐ Infective Endocarditis
☐ Leukemia
☐ Liver disease (jaundice or hepatitis)
☐ Rheumatic Fever
☐ Sickle Cell Anemia
☐ Sinus problems
☐ Prosthetic(Artificial) heart valve
☐ Warned against taking any medication

List Medication……..…...….

(Women) Are you ☐Pregnant ☐Nursing ☐Taking birth control pills

Social History ☐ Smoking (cigarettes daily) ……...… ☐ Drinking (drinks daily)..…….……

PHYSICIAN'S NAME AND ADDRESS…….…..….
DATE OF THE LAST PHYSICIAN'S VISIT……..…
REASON FOR VISIT TO DENTAL OFFICE……..

PHOTO ID- ☐ PASSPORT ☐DRIVER'S LICENSE ☐NATIONAL ID CARD :VERIFIED BY….……

There is a $43 fee for confirmed appointments that are cancelled less than 24 hours in advance and appointments that were confirmed and you failed to show or missed.

Date……...…….. Patient's signature……..