Welcome to Our Office

Thank you for choosing our office!

In order to serve you properly, we will need the following information. All information is strictly confidential. (Please print)

Patient's Name:_____
(Last) (First) (MI)

Social Security:_____-_____-_____ Sex: (F) (M) Date of Birth:_____

Responsible Party Information:

Name:_____ Marital Status:_____
(Last) (First) (MI)
Address:_____
(City) (State) (Zip Code)

Home Phone Number:_____ Cell:_____

Work:_____ Email:_____

Date of Birth:_____ Relationship to Patient:_____

Reason for Today's Visit?_____

Emergency Contact Name:_____

Emergency Phone Number:_____

Who can we thank for referring you to our office? Please check one below with name if possible
Family ____ Friend ____ Facebook ____ Google____ Insurance _____ Internet ____
Flyer ____ Someone at El Rancho ____ Someone at Fiesta ____ Walk By ____ Other ____
Name of Referral:_____

Insurance Information:

Name of Primary Acct Holder:_____
(Last) (First) (MI)
Name of Insurance Company:_____

Subscriber/Member I.D./ SSN:_____Group Number:_____

Subscriber/Member D.O.B:_____ Insurance Phone Number:_____

Dental History:

When was the patients last visit to the Dentist?_____

What was the reason for the patients last visit?_____

When was the patients last cleaning?_____

Is the patient having any sensitivity towards hot or cold food/drinks? [Y] [N]

Is the patient in pain? [Y] [N]

Medical History:

Are you seeing a physician? [Y] [N]

Name and address of physician(s):_____

What medications is the patient currently taking?_____

(Females) Are you pregnant? [Y] [N] If yes, how far along?_____

Circle any of the following which you had or have at present:

Heart Disease	Scarlet Fever	Hay Fever	HIV
High Blood Pressure	Anemia	Nervousness	Hepatitis
Blood Disease	Kidney Disease	Thyroid Disease	
Rheumatic Fever	Epilepsy or Seizure	Arthritis	
Heart Murmur	Ulcers	Sickle Cell Disease	
High Cholesterol	Heart Pacemaker	Tuberculosis	
Glaucoma	Diabetes	Asthma	
Pain in Jaw	Other:_____		

Circle any of the following medications you are allergic to:

Local Anesthetic	Sulfa Drugs	Latex
Codeine	Penicillin	
Aspirin	Other:_____	

To the best of my knowledge, all of the following answers are correct. I will notify the office if there are any changes to my health or changes in my medication consumption at next appointment.

X_____ Date:_____

Office Use Only

Dentist Signature:_____ Date:_____