Method of Payment
❑ Cash ❑ Check
❑ Credit Card

Welcome To Our Practice

Please Print Clearly

Date _____

Patient: (Mr., Mrs., Ms., Dr.) First Name _____ M.I. _____ Last Name _____

Zip Code: _____ Address: _____ City: _____ State: _____ Hm# (___) _____

Wk# (___) _____ Ext. _____ Employer _____ **D.O.B.** _____ **Age** _____ **Weight** _____ **Height** _____

Sex: ❑ Male ❑ Female Social Security # _____ Marital Status: _____ Driver's License # _____

Dentist: _____ Physician: _____ Referred By: _____

Who will be responsible for your account? ❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other _____ Responsible Party's DL#: _____

Spouse's Name: _____ Employer: _____ **D.O.B.:** _____ SS# _____

Father's Name: _____ Zip: _____ Address: _____ City _____ State _____

Hm# _____ Employer _____ Wk# _____ D.O.B. _____ SS# _____ DL# _____

Mother's Name: _____ Zip: _____ Address: _____ City _____ State _____

Hm# _____ Employer _____ Wk# _____ D.O.B. _____ SS# _____ DL# _____

Have you or a family member ever been a patient of our practice? ❑ Yes ❑ No Whom: _____ When: _____

Do you have Insurance? ____Dental ____Medical Alternate or Cell Phone # (____) _____

Reason for today's office visit? _____

PERSONAL HEALTH QUESTIONNAIRE (Please Circle Yes or No)

1. Yes No Are you in good general health _____
2. Yes No Are you presently under a physician's care _____
3. Yes No Have you had any surgeries or been put asleep for anything, or hospitalizations: (Please list): _____
4. Yes No Have you been taking any medicines, herbs or drugs now or within the past year? (Including birth control pills) _____

MEDICINE	MEDICINE

5. Yes No **DO YOU HAVE ANY DRUG ALLERGIES, IF YES PLEASE LIST:** _____

HAVE YOU HAD OR EVER SUSPECTED ANY OF THE FOLLOWING CONDITIONS (Please Circle Yes or No)

Yes	No	Cancer	Yes	No	Kidney or Bladder Trouble
Yes	No	Heart Disease (Please Circle): Rheumatic Fever, Heart Murmur, Chest Pain, Heart Attack, Stroke, Shortness of Breath, Ankle Swelling	Yes	No	Diabetes
			Yes	No	Stomach Ulcers
			Yes	No	Seizures
Yes	No	High Blood Pressure	Yes	No	Arthritis or Joint Pain
Yes	No	Respiratory Disease (Please Circle): T.B., Persistent Cough, Asthma, Sinus Trouble, Hay Fever.	Yes	No	Radiation Treatments or X-ray Therapy
			Yes	No	Psychiatric Problems
			Yes	No	Are you Pregnant
Yes	No	Fainting Tendency	Yes	No	Disease or drug that has depressed your immune system/ or medications to strengthen your bones (bisphosphonates)
Yes	No	Frequent Headaches			
Yes	No	Abnormal Bleeding or Bruise Easily	Yes	No	Do you Smoke or use Tobacco
Yes	No	Thyroid Disease	Yes	No	Do you use Alcohol
Yes	No	Hepatitis, Jaundice or Liver Disease	Yes	No	Do you use Recreational Drugs (Marijuana, Cocaine, etc.)

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: _____ **Date:** _____
(or legal guardian if a minor)