PATIENT'S LAST NAME | FIRST | MIDDLE | HOME PHONE | CELL | DATE OF BIRTH

HOME ADDRESS | CITY | ZIP | MARITAL STATUS | PARENTS/SPOUSE'S NAME

EMPLOYED BY | CITY | STATE | BUSINESS PHONE | SOCIAL SECURITY NUMBER

PRESENT POSITION | HOW LONG HELD | REFERRED BY

NAME OF PERSON RESPONSIBLE FOR ACCOUNT | SOCIAL SECURITY NUMBER | DRIVERS LICENSE NUMBER

EMPLOYED BY | CITY | STATE | BUSINESS PHONE | POSITION-HOW-LONG

PHYSICIAN'S NAME_____ DATE OF LAST PHYSICAL EXAM_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING. PLEASE INDICATE WITH CHECK MARK

___ANY HEART PROBLEMS
___HIGH BLOOD PRESSURE
___LOW BLOOD PRESSURE
___CIRCULATORY PROBLEMS
___NERVOUS PROBLEMS
___RADIATION TREATMENTS
___EXCESSIVE BLEEDING
___ALLERGIES TO ANESTHETICS
___ALLERGIES TO MEDICINES OR DRUGS

___ALLERGIES TO_____
___ANEMIA
___ARTHRITIS
___ASTHMA
___DIABETES
___HEPATITIS
___MALIGNANCIES
___MEASLES
___MUMPS

___PSYCHIATRIC CARE
___RHEUMATIC FEAVER
___SCARLET FEVER
___SINUS PROBLEMS
___STROKE
___TYPHOID FEVER
___TONSILLITIS
___TUBERCULOSIS
___ULICER

___HIV

ARE YOU PREGNANT?_____

BLOOD PRESSURE:

S_____/ D_____/ _____

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT, IMPENDING OPERATIONS, OR ANY OTHER MEDICAL OR DENTAL INFORMATION THAT MAY POSSIBLY AFFECT YOUR DENTAL TREATMENT.

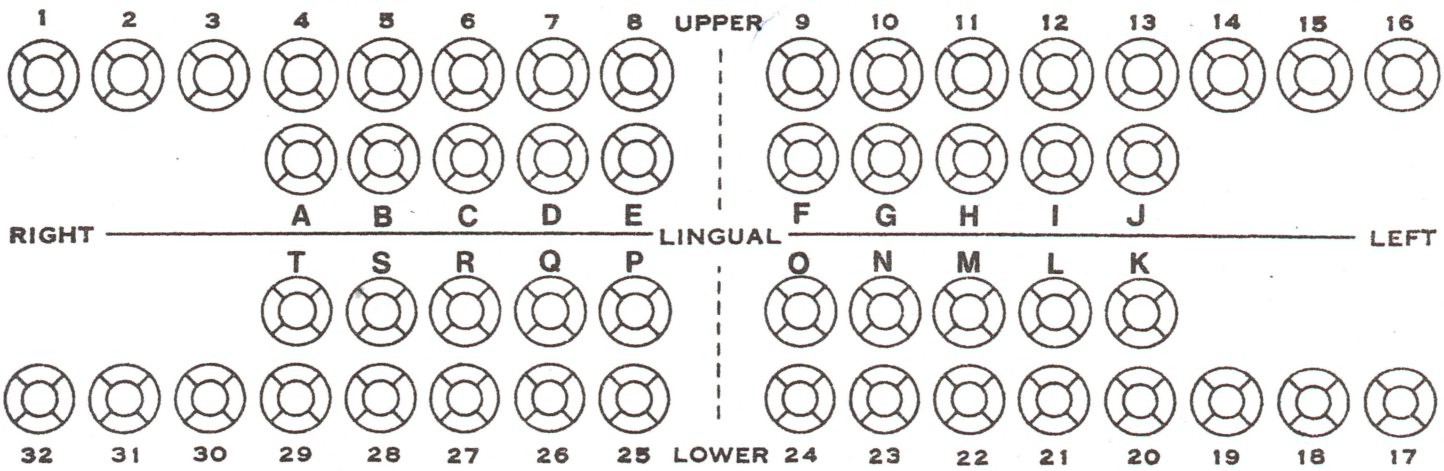
_____

_____

In the event your account becomes delinquent for more than 90 days, you agree to pay a finance charge of 18% per month on any balance due. In the event your account is submitted for collection, in addition to interest charged, you agree to pay all collection costs, including, but not limited to attorney's fees and court cost.

_____ _____

PATIENT/PARENT'S SIGNATURE DATE



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