PATIENT INFORMATION

Whom may we thank for referring you?_____
Reason for this visit/Chief complaint_____

Today's Date_____ **Patient Name**_____
(Last) (First) (M.I.)
Address_____
(Street) (City, State, Zip)
Home Phone:_____ **Cell Phone:**_____
E-Mail Address:_____
SS#_____ **Drivers License #**_____
Date of Birth_____ ____**Single** ____**Married**

If patient is a minor, give parent/guardian information:
Name_____
Address_____
Date of Birth_____ **SS#**_____ **Phone**_____

If patient is a full time student, give school name_____

Spouse information:

Name of Spouse_____
Spouse date of birth_____ **Spouse SS#**_____

Employment Information
Patient:
Name of employer_____
Employer address_____
Employer telephone number_____
Occupation_____

Spouse:
Name of employer_____
Employer address_____
Employer telephone number_____
Occupation_____

MEDICAL HISTORY

Indicate which of the following you have or have had at the present: Circle yes or no to each item listed.

Heart Disease or Attack	Yes No	Tuberculosis	Yes No
Angina Pectoris	Yes No	Asthma/Emphysema	Yes No
Congenital Heart Disease	Yes No	Allergies/Hives	Yes No
Heart Murmur	Yes No	Sinus Trouble	Yes No
High Blood Pressure	Yes No	Chemotherapy	Yes No
Heart Pacemaker	Yes No	Radiation Therapy	Yes No
Heart Surgery	Yes No	Hepatitis A (infectious)	Yes No
Rheumatic Fever	Yes No	Hepatitis B (serum)	Yes No
Drug Addiction	Yes No	Allergy to Latex	Yes No
Artificial Joint	Yes No	A.I.D.S.	Yes No
Kidney Trouble	Yes No	H.I.V. Positive	Yes No
Ulcers`	Yes No	Cold Sores/Fever Blisters	Yes No
Diabetes	Yes No	Blood Transfusion	Yes No
Thyroid Problems	Yes No	Anemia	Yes No
Glaucoma	Yes No	Sickle Cell Disease	Yes No
Cancer	Yes No	Liver disease/Jaundice	Yes No
Stroke	Yes No	Epilepsy or Seizures	Yes No
Fainting/Dizzy Spells	Yes No	Nervousness	Yes No

Do you have or had any disease, condition or problem not listed ____yes ____no
If yes, please list:_____
Please list any and all medications taken daily with dosages:
_____
Are you allergic or sensitive to any medications or anesthesia ____yes ____no
If yes, please list:_____

Physician name:_____
Address:_____
Phone:_____

1. I, the undersigned hereby authorize the doctor to take x-rays, study models, photographs or any other diagnostic aides deemed appropriate to make a thorough diagnosis of my dental needs.
2. I understand that the responsibility for payment of dental services provided in this office for myself or my dependant is mine, due and payable to Thomas Torre.
3. I understand that where appropriate, credit bureau reports may be obtained.
4. I understand that it is my responsibility to advise this office of any changes in information contained on this form.
5. I understand the above information is necessary to provide me with dental care in a safe and efficient manner and I have answered all the questions truthfully and to the best of my knowledge.

Patient signature_____**Date**_____

INSURANCE INFORMATION

Insured
Name:_____

Insured Date of Birth:_____

Insured ID Number:_____

Patient Name:_____

Patient Relationship:_____

Patient Date of Birth:_____

Insurance Company:_____

Insurance Address:_____
_____

Are you covered by another dental insurance? ___yes no___

If yes, please complete:

Insured Name:_____

Insured Date of Birth:_____

Insured ID Number:_____

Insurance Company:_____

Insurance Address:_____
_____

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan:

X_____
Patient/Guardian signature