



NAME: _____ Birth date: _____

Mailing Address: _____ City, State, Zip _____

E-mail Address: _____ Occupation: _____

Marital Status: [] Single [] Married [] Divorced [] Widowed

Who referred you to our office / How did you hear about our office? _____

Phones numbers: Work _____ Home _____ Cell _____

Account Responsible if someone other than yourself: Name: _____

Dental Insurance Company: _____ Employer: _____

Name of Policy Holder: _____ Insurance ID or SSN#: _____

Date of Birth: _____ Group #: _____

HEALTH HISTORY - Have you ever had any of the following? Please check YES or NO

Table with 2 columns of health history questions and checkboxes for Yes/No. Questions include: Are you in good health, Has your health changed in the last year, Chest Pain or Shortness of Breath, Bleeding Problems or Bruise Easily, Blood Thinners / Coumadin, Headaches or Ringing in Ears, Joint Replacement, Fainting or Seizures, Heart Disease, Murmurs, Rheumatic Fever or Mitral Valve Prolapsed, Pacemaker or Prosthetic Heart Valve, Osteoporosis or Osteopenia, High Blood Pressure, Hepatitis or Liver Disease, Latex Allergy, Diabetes, Tumors or Cancer, Radiation / Chemotherapy, Psychiatric Care, Kidney or Bladder Disease, VD, Herpes, HIV positive, AIDS, ARC, Now Pregnant: Month _____, Birth Control Pills, Acid Reflux / Heartburn, Problem with Dry Mouth, Recreational Drugs, Smoking or Alcohol, Asthma, TB or Lung Disease.

List any and all DRUG ALLERGIES, including over the counter medications: _____

List any and all DRUGS/MEDICATIONS/HERBS/SUPPLEMENTS you are taking: _____

List any and all SURGERIES: _____

Are you being treated by a doctor now? [] Yes [] No Who: _____

The above information is true and correct to the best of my knowledge

Patient Signature: _____ Date: _____

Photo Release:

I give Ideal Dentistry, Inc. authorization to use my photographs in the dental office, practice marketing materials, website and brochure.

Patient Signature: _____ Date: _____

