

PERSONAL INFO	Part 1		
	Social Security # : _____		Date of Birth : _____ / _____ / _____ Month Day Year
	Name _____ First Name Last Name Middle Initial		
	Address _____ (Street, Av,....?)		Apt. <input type="text"/> City <input type="text"/> ZIP Code <input type="text"/>
	Email: _____		
	Telephone: () _____ () _____ () _____ Home Celular Work		
	Sex _____ Height _____ Weight _____ Civil Status: Single <input type="checkbox"/> Married <input type="checkbox"/> Widow <input type="checkbox"/> Divorced <input type="checkbox"/>		
	Friend or Close Relative: _____ Name Telephone		

INSURANCE	Part 2	
	Employer's Name _____ Occupation _____	
	Dental Insurance Name: _____ Dental Group Number _____	
	Who provides you with this dental Ins Coverage? : Yourself <input type="checkbox"/> Your husband or Wife <input type="checkbox"/> Father or Mother <input type="checkbox"/>	
	Name and SS # of the Person _____ # _____ who provides you with this Insurance Name Social Security	

MEDICAL HISTORY	Part 3	
	Name & telephone of your Primary Doctor _____	
	Date of last complete phisical: _____	
	Are you taken any medication? Yes <input type="checkbox"/> No <input type="checkbox"/> (If answer is yes) for what purpose ? _____	
	Are you allergic to: Penicillin <input type="checkbox"/> Codeine <input type="checkbox"/> Local Anesthesia <input type="checkbox"/> Other medications ? _____	
	Have you have had any of the following?	
	Rheumatic Fever Yes <input type="checkbox"/> No <input type="checkbox"/>	Allergy Yes <input type="checkbox"/> No <input type="checkbox"/>
	High/Low Pressure Yes <input type="checkbox"/> No <input type="checkbox"/>	Sinusitis Yes <input type="checkbox"/> No <input type="checkbox"/>
	Ulcers Yes <input type="checkbox"/> No <input type="checkbox"/>	Asthma Yes <input type="checkbox"/> No <input type="checkbox"/>
	Tuberculosis Yes <input type="checkbox"/> No <input type="checkbox"/>	Arthritis Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes. Yes <input type="checkbox"/> No <input type="checkbox"/>	Glaucoma Yes <input type="checkbox"/> No <input type="checkbox"/>	
Epilepsy Yes <input type="checkbox"/> No <input type="checkbox"/>	Nervous Problems Yes <input type="checkbox"/> No <input type="checkbox"/>	
Anemia Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney problems Yes <input type="checkbox"/> No <input type="checkbox"/>	
HIV Virus Yes <input type="checkbox"/> No <input type="checkbox"/>	Fainting spells Yes <input type="checkbox"/> No <input type="checkbox"/>	
WOMEN ONLY: Are you pregnant (or suspect that you are) Yes <input type="checkbox"/> No <input type="checkbox"/> Are you taking BirthControl pills? Yes <input type="checkbox"/> No <input type="checkbox"/>		

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I authorize the doctor to release all the information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I agree that parents are responsible for all fees and services rendered for treatment of a child. I authorize the use of this signature on all insurance submissions.

Date _____ / _____ / _____ Signature: _____
Month Day Year Signature of adult required

Medical History Update		
Date:	Health Changes? Yes <input type="checkbox"/> No <input type="checkbox"/> If YES Explain	Signature:
Date:	Health Changes? Yes <input type="checkbox"/> No <input type="checkbox"/> If YES Explain	Signature:
Date:	Health Changes? Yes <input type="checkbox"/> No <input type="checkbox"/> If YES Explain	Signature: