Name: _____ Date of Birth: _____

If child, parent's or guardian's name: _____

Address: _____

Mailing Address: _____

Main phone # _____ Work # _____Social Security # _____

E-Mail Address: _____Marital Status: _____

Employer: _____ Emergency contact: _____

Insurance Information:

Insurance company: _____ Subscriber name: _____

Subscriber birthdate: _____Employer name: _____ Group #_____

Subscriber ID # _____ Social Security # of Subscriber: _____

Secondary Insurance Co: _____ Subscriber name: _____

Subscriber birthdate: _____ Employer name: _____

Subscriber ID # _____ Social Security # of Subscriber: _____

Health History

Do any of the following apply?

Heart Problem	yes	no	Organ transplant	yes	no	Cancer	yes	no
Artificial Joint	yes	no	Radiation/chemotherapy	yes	no	Ulcers	yes	no
High blood pressure	yes	no	Epilepsy	yes	no	Stroke	yes	no
Bleeding problems	yes	no	Hepatitis	yes	no	Tested positive for HIV	yes	no
Emphysema/lung disease	yes	no	Tuberculosis	yes	no	Osteoporosis	yes	no
Diabetes	yes	no	Immune Disorder	yes	no	Nervous/mental condition	yes	no

Physician's name_____ Date of last physical _____

Are you taking any medication, drugs, or pills? yes no

If yes, please list those medications _____

Are you allergic or have you reacted adversely to any medication? yes no

If so, please list _____

Do you smoke? yes no

Do you have any disease, condition, or problem not listed above which we should know about?

_____

Women only: Are you pregnant? yes no If yes, what month? _____ Do you take birth control pills? yes no

Consent: Please read before signing:

The undersigned hereby authorizes Dr. Haines and staff to take radiographs, study models, photographs and perform treatment, medication and therapy that may be indicated in connection with my needs. I also understand that the use of anesthetic agents embodies a certain risk. **I understand that I am financially responsible for all charges regardless of insurance coverage**. I understand that the office requires payment for services at the time of visit unless prior arrangements have been made.

Signature _____ Relationship to patient _____ Date _____

Your signature is a file signature for insurance and credit card transactions

See Other Side Please

What do you hope to accomplish with the time you spend with us?

What are some of the questions about dentistry and your oral health that you would like answered?

Is there anything about the appearance of your teeth or smile that you would change if you could?

Does dental treatment make you nervous?

If yes; Is there anything we can do to make your visit more comfortable?

Are there any other considerations you would like us to understand?