

FULL NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: cell \_\_\_\_\_ ok to receive texts? \_\_\_ home \_\_\_\_\_

EMAIL: \_\_\_\_\_ PREFERRED CONTACT METHOD :c / h email

OCCUPATION: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_ SPOUSE'S NAME: \_\_\_\_\_

PERSON RESPONSIBLE FOR PAYMENT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

EMERGENCY CONTACT name and **phone #**:

\_\_\_\_\_

Your relationship to emergency contact: \_\_\_\_\_

WHO MAY WE THANK FOR YOUR REFERRAL, OR HOW DID YOU CHOOSE OUR OFFICE? \_\_\_\_\_

\_\_\_\_\_

**IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE FOLLOWING SECTION:**

PRIMARY INSURED PERSON, and your relationship to them: \_\_\_\_\_

TYPE OF INSURANCE/NAME OF INSURANCE COMPANY: \_\_\_\_\_

INSURED'S EMPLOYER, IF EMPLOYER-SPONSORED PLAN: \_\_\_\_\_

PRIMARY INSURED'S SS# \_\_\_\_\_ MEMBER ID \_\_\_\_\_

PRIMARY INSURED'S DOB, if other than yourself: \_\_\_\_\_ GROUP# \_\_\_\_\_

***PLEASE PROVIDE US WITH YOUR INSURANCE CARD***

***If you have more than one dental insurance, please notify us***

**HEALTH HISTORY AND INFORMATION**

What medications, drugs, or supplements are you now taking? (if you carry a list, we can copy into your record for your convenience): \_\_\_\_\_

\_\_\_\_\_

**ALLERGIES OR SENSITIVITIES:** \_\_\_\_\_

Gender: \_\_\_\_\_ Height: \_\_\_\_\_ Weight \_\_\_\_\_

Do you use tobacco? \_\_\_ If so, what type, how much? \_\_\_\_\_ VAPE? \_\_\_\_\_

Are you pregnant now? \_\_\_\_\_ # of weeks: \_\_\_\_\_

(OVER)

**CIRCLE ANY OF THE FOLLOWING THAT YOU NOW HAVE OR HAVE HAD IN THE PAST, and date of treatment or diagnosis, if known:**

Recent surgery or hospitalization \_\_\_\_\_

Heart disease

Heart attack (date \_\_\_\_\_)

Heart surgery (date \_\_\_\_\_)

Congenital heart defect

Joint replacement (date \_\_\_\_\_)

High blood pressure

Low blood pressure

Kidney problems

Asthma

Cancer

Chemotherapy

Radiation

Liver disease

Diabetes

Thyroid disease

Drug abuse or dependency

Epilepsy or seizures

Hemophilia, bleeding disorder

Psychiatric problems

Hard of hearing

Sleep apnea or snoring

**OTHER** \_\_\_\_\_

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have changes to any of the above information, I will inform the doctor or staff at my next appointment.

Signature: \_\_\_\_\_ (or parent/guardian if patient under 18)

Date: \_\_\_\_\_

Thank you from the Voller Dentistry Team!