

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? _____

Marijuana use? _____ What form? _____ Are you pregnant? ___ # of weeks: _____

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!