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: _____

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, and how much? _____

Are you pregnant now? _____ # of weeks: _____

(SEE PAGE 2)

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, heart surgery
Congenital heart condition
Anemia
Angina Pectoris
Arthritis
Joint replacement
High or low blood pressure
Kidney problems
Stroke
Ulcers
Asthma
Lung disease
Cancer
Tuberculosis
Venereal disease
Liver disease or Hepatitis
Diabetes
Sinus problems
Thyroid disease
Colitis, intestinal problems, Crohn's Disease
Sickle Cell Disease
Abnormal bleeding from wound or surgery
AIDS
Tumor, cyst
Chemotherapy or radiation treatment
Drug abuse or dependency
Epilepsy or seizures
Hemophilia, bleeding disorder
Psychiatric treatment
Hard of hearing
Vision problems
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!