Welcome To Our Family Practice

PATIENT INFORMATION

WHO MAY WE THANK FOR REFERRING YOU TO THIS OFFICE? _____

Patient's Full Name:_____ Home Phone #:_____ Work # / EXT:_____

Home Address:_____ City/State/Zip:_____ Cell #:_____

DOB (M/D/Y):_____ Age:_____ Marital Status: S___M___D___W___ Email Address:_____

Social Security #:_____ Employer:_____ Occupation:_____

Spouse's Name:_____ Spouse's Soc. Security #:_____ Occupation:_____

Spouse's Employer:_____ Spouse's Work # / EXT:_____ Cell #:_____

PERSON TO CONTACT IN CASE OF EMERGENCY (Not Living With You): Name: _____

Home Address:_____ City/State/Zip:_____ Cell #:_____

Home Phone #:_____ Work # / EXT:_____ Relationship:_____

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT

First Name:	MI:	Last Name:	Relationship:	
Street Address:		City:	State:	Zip:
Home Phone #:	Work Phone # / EXT:	Social Security #:	Occupation:	
Employer:	Employer Street Address (City, State, Zip):		Length of Employment:	

PRIMARY INSURANCE INFORMATION (use your identification card)

Dental Insurance Company:	Address where claim should be sent:		Phone #:
Policyholder's Name:	Policyholder's Birthdate (M/D/Y):	Policyholder's Social Security #:	
Name of Group Employer:	Group #:	Plan Name:	Relationship to Policyholder:

SECONDARY INSURANCE INFORMATION (if applicable)

Dental Insurance Company:	Address where claim should be sent:		Phone #:
Policyholder's Name:	Policyholder's Birthdate (M/D/Y):	Policyholder's Social Security #:	
Name of Group Employer:	Group #:	Plan Name:	Relationship to Policyholder:

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a 1.5% finance charge (18% annually) will be added to any balance over 60 days from the date of service. If this account is assigned to an outside collection agency for collection, I/we agree to pay all attorney fees, court costs, and a collection charge of up to 50%, which will be added to the outstanding balance of my account. I understand that Warr Dental will submit all necessary insurance claims on my behalf but all charges incurred are ultimately my responsibility. I certify that I have answered all questions on this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined hereon.

X _____ Date: _____

PATIENT SIGNATURE (PARENT OR GUARDIAN)

MEDICAL HISTORY

Please Circle

1. Are you experiencing pain or discomfort? YES NO
2. Are you in good health? YES NO
3. Has there been a change in your general health within the past year? YES NO
4. Are you under the care of a physician? YES NO
   If so, what condition is being treated?

PHYSICIAN'S NAME	CITY/STATE	PHONE NO.

5. Have you been hospitalized or had a serious operation or illness within the last 5 years? YES NO
6. Do you now have or have you ever had any of the following? *Please Circle Y or N*
   ***** If yes to any of the starred conditions, premedication may be required.

Y	N	Heart Failure, Disease, or Attack *****	Y	N	Emphysema	Y	N	Diabetes: Type I, Type II
Y	N	Artificial Joint *	Y	N	Chronic Cough	Y	N	Thyroid Disease
Y	N	Heart Murmur *	Y	N	Tuberculosis (TB)	Y	N	X-ray or Cobalt Treatment
Y	N	Mitral Valve Prolapse *	Y	N	Asthma	Y	N	Chemotherapy (Cancer, Leukemia)
Y	N	Rheumatic Fever *	Y	N	Hay Fever	Y	N	Arthritis
Y	N	Artificial Heart Valve *	Y	N	Sinus Trouble	Y	N	Rheumatism
Y	N	Heart Pace Maker *	Y	N	Allergies or Hives	Y	N	Pain in Jaw Joints
Y	N	Heart Surgery *	Y	N	Glaucoma	Y	N	Fainting or Dizzy Spells
Y	N	Scarlet Fever	Y	N	Anemia	Y	N	Epilepsy or Seizures
Y	N	Congenital Heart Lesions	Y	N	Stroke	Y	N	Cold Sores
Y	N	AIDS or HIV-related Disorders	Y	N	Kidney Trouble	Y	N	STD or VD (Syphilis, Gonorrhea)
Y	N	Hepatitis A B C	Y	N	Ulcers or G.E.R.D.	Y	N	Blood Transfusion
Y	N	High Blood Pressure	Y	N	Bruise Easily	Y	N	Nervousness
Y	N	Liver Disease	Y	N	Sickle Cell Disease	Y	N	Metal Allergies
Y	N	Yellow Jaundice	Y	N	Psychiatric Treatment			
Y	N	History of Drug Addiction	Y	N	Hypoglycemia			

7. Are you taking any drug, medicine, or dietary supplements? YES NO
   If yes, please list:
8. Have you ever taken Fosamax, Boniva or Reclast? YES NO
9. Are you allergic or have you reacted adversely to any drugs or medicines? YES NO
   If yes, please list:
10. Are you currently using or have you ever used tobacco? YES NO
    If yes, what form? How often?
11. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest? YES NO
12. Have you had any serious trouble associated with any previous dental treatment such as abnormal bleeding? YES NO
    If yes, please explain:
13. Do you have a disease, condition, or problem not listed above that you think I should know? YES NO
14. Do you have a history of snoring? YES NO
15. Have you ever been diagnosed with sleep apnea? YES NO
16. Do you wear a CPAP machine? YES NO
17. *FOR WOMEN ONLY*: Are you pregnant? YES NO
    If yes, what month? Are you taking birth control pills? YES NO

CONSENT: The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with the patient and further authorize and consent that Doctor choose and employ such assistance as he/she deems fit. I also understand the use of anesthetic agents embodies a certain risk.

I certify that I have answered all questions on this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined hereon.

X _____ Date: _____

PATIENT SIGNATURE (PARENT OR GUARDIAN)

MEDICAL HISTORY UPDATE

I have reviewed my original health history above and certify that it is accurate except for the changes indicated below:

Date	Health Changes/Current Medications		Patient's Signature	Blood Pressure	Reviewed By
		None ☐			
		None ☐			
		None ☐			
		None ☐			
		None ☐			
		None ☐			