SIGNATURE DENTISTRY
AND IMPLANT CENTER

DATE:_____

PATIENT INFORMATION

NAME:_____ SSN:_____
ADDRESS:_____ DRIVER'S LICENSE NUMBER:_____
CITY:_____ STATE:_____ ZIP CODE:_____ BEST PHONE NUMBER:_____
EMAIL ADDRESS:_____
DATE OF BIRTH:_____ GENDER: M / F MARITAL STATUS:_____
IN CASE OF EMERGENCY WHO SHOULD BE NOTIFIED:_____ PHONE NUMBER:_____
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE:_____

EMPLOYER INFORMATION

EMPLOYER NAME:_____ OCCUPATION:_____

PRIMARY DENTAL INSURANCE INFORMATION

NAME OF DENTAL INSURANCE AS DISPLAYED ON YOUR ID CARD:_____
NAME OF INSURANCE SUBSCRIBER:_____ REALTIONSHIP TO PATIENT:_____
INSURANCE SUBSCRIBER DOB:_____ INSURANCE ID NUMBER:_____
INSURANCE COMPANY PHONE NUMBER:_____ DO YOU HAVE ADDITIONAL DENTAL INSURANCE: Y / N

MEDICAL PROVIDER INFORMATION

PRIMARY CARE PHYSICIAN NAME:_____ PHONE NUMBER:_____
PHYSICIAN ADDRESS:_____
CITY:_____ STATE:_____ ZIP CODE:_____

WE ASK FOR A COPY OF YOUR IDENTIFICATION, ALL INSURANCE CARDS, AND A LIST OF CURRENT MEDICATIONS.

CIRCLE IF YOU HAVE/HAD ANY OF THE FOLLOWING:

SNORING	MORNING HEADACHES	TIREDNESS DURING THE DAY
ACID REFLUX / GERD	JAW PAIN / CLICKING	GRINDING TEETH ANXIETY / DEPRESSION
BLEEDING GUMS	POLYCYSTIC OVARIAN SYNDROME	TOOTH SENSITIVITY: HOT / COLD / SWEETS / BITING
MOOD DISTURBANCE	SUBSTANCE ABUSE	FREQUENT URINATION DURING SLEEPING HOURS
IRRITABLE BOWEL SYNDROME	ERECTILE DYSFUNCTION	STOP BREATHING WHILE SLEEPING/APNEA
WEIGHT GAIN	INSOMNIA	RESTLESS LEG SYNDROME

AIDS / HIV POSITIVE	DIABETES	KIDNEY DISEASE	SHORTNESS OF BREATH	**ALLERGY TO:**
ANAPHALAXIS	EPILEPSY	LIVER DISEASE	SKIN CONDITIONS	**ASPIRIN**
ANEMIA	GLAUCOMA	NERVOUS PROBLEMS	STROKE	**CODEINE**
ARTHRITIS	HEART MURMUR/MVP	PACEMAKER	SURGICAL IMPLANTS	**CLINDAMYCIN**
ARTIFICAL JOINTS / VALVES	HEART PROBLEMS	PREGNANT OR NURSING	SWELLING OF FEET /ANKLES	**HAY FEVER**
ASTHMA	HEMOPHILIA	PSYCHIATRIC CARE	THYRIOD DISEASE	**LATEX**
BACK PROBLEMS	HEPATITS: A B C	RADIATION TREATMENT	TOBACCO HABIT	**PENICILLIN**
CANCER	HERPES	RESPIRATORY DISEASE	TUBERCULOSIS	**SULFA**
CHEMOTHERAPY	HIGH BLOOD PRESSURE	RHEUMATIC/SCARLET FEVER	ULCERS / COLITIS	**IODINE**
CIRCULATORY PROBLEMS	HPV	SHINGLES	SEXUALLY TRANSMITTED DISEASES	**OTHER:**_____

TO THE BEST OF MY KNOWLEDGE, THE QUESTIONS ON THIS FORM HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY (OR PATIENT'S) HEALTH. IT IS MY RESPONSIBILITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES IN MEDICAL STATUS.

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SIGNATURE OF PATIENT / PARENT / GUARDIAN / POWER OF ATTORNEY DATE