Medical Profile

Please answer all questions as completely as possible. Your responses are held in the strictest of confidence and are not reported to any health agency, insurance company, employer or other persons. We require this information in order to make an accurate diagnosis to insure your safety.

Patient's Name_____
Date of Birth_____Age_____Marital Status_____
Sex____ Height_____Weight_____ Presently under a doctor's care?_____
If so, please explain:_____
Presently taking any medications?_____
If so, please explain:_____
Any allergies or adverse reactions to medication?_____
If so, please explain:_____
(Females) are you currently or possible pregnant?_____

Have you ever had any of the following:

Yes	No		Yes	No	
☐	☐	Rheumatic Fever	☐	☐	Epilepsy/Seizures
☐	☐	Heart Attack	☐	☐	Headaches
☐	☐	Mitral valve Prolapse	☐	☐	Diabetes
☐	☐	Heart Murmer	☐	☐	Thyroid Disorders
☐	☐	Heart Surgery	☐	☐	Hepatitis/Liver Disease
☐	☐	Artificial Heart Valves	☐	☐	Arthritis
☐	☐	Other Heart Ailments	☐	☐	Venereal Disease
☐	☐	Artificial Joints	☐	☐	HIV
☐	☐	High Blood Pressure	☐	☐	Chemical Dependency
☐	☐	Low Blood Pressure	☐	☐	Use of Tobacco
☐	☐	Circulatory Problems	☐	☐	Hemophilia
☐	☐	Back Problems	☐	☐	Abnormal Bleeding
☐	☐	Respiratory Disease	☐	☐	Anemia
☐	☐	Sinus Problems	☐	☐	Cancer
☐	☐	Bronchial Asthma	☐	☐	Radiation Therapy (excludes routine x-rays)

If there anything else we should know about your medical history, please explain:_____
_____
If you have had problems with previous dental treatment, please explain:_____
_____

Patient Information Profile:

Today's Date_____
Patient's Name_____
Parent's Name (if patient is minor)_____
Address_____City_____State_____Zip_____
Home Phone_____Work Phone_____
Social Security No._____
Employer_____
Employer's Address_____
Spouse's Name_____Work Phone_____
Spouse's Social Security No._____
Nearest Relative (not living with you)_____
Address_____Phone_____
Nearest Friend (not living with you)_____
Address_____ Phone_____
Family Physician_____ Phone_____
In case of emergency, whom should we contact?_____
Address_____ Phone_____
Whom may we thank for referring you?_____

Financial Policies:

We do not have billing system, therefore, full payment is expected at the time of treatment, unless payment arrangements have been approved in advance by our office. For you convenience we accept VISA, Mastercard, Discover Card, personal check, cash and assignment of *dental* insurance benefits. Balances older than 30 days will be subject to interest charges of 1.5% per month. Charges may also be made for broken appointments and appointments canceled without 24 hours advance notice. If it is necessary to use a collection agency to collect any moneys owed by you to this practice, you may be responsible for collection agency and/or legal fees.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes to my health status or the above information.

_____Date_____
(Signature of Patient or Parent if Minor)