Welcome to our office. It is our sincere hope that your treatment will be comfortable and satisfying. This is not a test. Please take a few minutes to complete this side only. If you have any questions or need some help, don't hesitate to ask.

NAME ____
FIRST MIDDLE LAST

ADDRESS ______________________ CITY ______________ STATE ____ ZIP CODE ________

HOME PHONE # ( ) ______________ WORK PHONE # ( ) ______________

PATIENT'S EMPLOYER ______________________________

EMPLOYER'S ADDRESS ______________________________

SOC. SECURITY # ______________ BIRTH DATE MTH____ DAY____ YR____

SEX ( )MALE ( )FEMALE **MARITAL STATUS** ( )SINGLE ( )MARRIED ( )DIVORCED ( )WIDOWED

EMERGENCY PHONE # ( ) ______________ DRIVER'S LICENSE # ______________

SPOUSE'S NAME ______________ SPOUSE'S SOC. SECURITY # ______________

SPOUSE'S BIRTH DATE MTH____ DAY____ YR____ SPOUSE'S EMPLOYER ______________

SPOUSE'S WORK PHONE # ( ) ______________ IS SPOUSE COVERED BY DENTAL INSURANCE? ( ) YES ( ) NO

INSURANCE CARRIER POLICY # ______________________________

RESPONSIBILITY PARTY'S NAME ______________ PERSON RESPONSIBLE FOR PAYMENT ______________

ADDRESS ______________________ CITY ______________ STATE ____ ZIP CODE ________

PHONE # ( ) ______________ BIRTH DATE MTH____ DAY____ YR____ SOC SECURITY # ______________

RESPONSIBLE PARTY'S EMPLOYER ______________ INS. CO. NAME ______________

WORK PHONE # ( ) ______________ DRIVER'S LICENSE # ______________ INSURANCE CARRIER POLICY # ______________

ARE YOU COVERED BY ANY OTHER INSURANCE? ( ) YES ( ) NO ______________

PHYSICIAN'S NAME ______________ ADDRESS ______________

PHONE # ( ) ______________ ARE YOU UNDER HIS CARE NOW? ( )YES ( )NO

DATE OF LAST MEDICAL CHECK UP OR VISIT? ______________

WHAT MEDICATIONS ARE YOU ALLERGIC TO? ______________

MEDICATION NOW BEING TAKEN: 1. ______________ DOSE: ______ 2 ______________ DOSE: ______
IF THERE ARE ADDITIONAL MEDICATIONS, PLEASE CONTINUE ON SEPARATE SHEET OF PAPER
3. ______________ DOSE: ______ 4 ______________ DOSE: ______

DATE OF LAST DENTAL VISIT? ______________

HOW CAN WE HELP YOU? ______________

HAVE WE SEEN OTHER MEMBERS OF YOUR FAMILY? ______________

DO YOU HAVE, OR HAVE HAD, ANY OF THE FOLLOWING? PLEASE PUT A CHECK NEXT TO ALL THAT APPLY.

____ ANY HEART PROBLEMS
____ HIGH BLOOD PRESSURE
____ LOW BLOOD PRESSURE
____ CIRCULATORY PROBLEMS
____ NERVOUS PROBLEMS
____ RADIATION TREATMENTS
____ EXCESSIVE BLEEDING
____ ALLERGIES TO ANESTHETICS
____ THYROID PROBLEMS
____ HIV/AIDS
____ LATEX ALLERGY
____ PREVIOUS SURGERY
____ CANCER/MALIGNANCIES

____ MUMPS
____ PSYCHIATRIC CARE
____ RHEUMATIC FEVER
____ SCARLET FEVER
____ SINUS PROBLEMS
____ STROKE
____ ASTHMA
____ ARTHRITIS
____ HEART MURMUR
____ MITRAL VALVE PROLAPSE
____ ANEMIA
____ DIABETES
____ EPILEPSY

____ TONSILITIS
____ TUBERCULOSIS / STILL ACTIVE? NO ___ YES ___
____ ULCER
____ VENEREAL DISEASE
____ HEPATITIS (DATE) ______________
IS YOUR DISEASE STILL ACTIVE? NO ___ YES ___
____ PREGNANT (DATE DUE) ______________
____ CARDIAC PACEMAKER
____ JOINT REPLACEMENT
____ PINS/PLATES OR IMPLANTS
____ GLAUCOMA
____ TAKEN PHEN/FEN OR REDUX

REVIEWED BY DOCTOR ______________ DATE: ________

HOW DID YOU HEAR ABOUT NORTH COAST DENTAL? ______________

I AGREE TO PAY FOR SERVICES AS THEY ARE RENDERED. IF PROCEDURES ARE COVERED IN WHOLE OR IN PART BY DENTAL INSURANCE, I AUTHORIZE PAYMENT TO NORTH COAST DENTAL, INC. INSURANCE COVERAGES GIVEN ARE ONLY ESTIMATES AND MAY BE INCORRECT. ANY AND ALL BALANCES WILL BE MY RESPONSIBILITY. A LATE FEE WILL BE CHARGED FOR PAST DUE ACCOUNTS.

X ____
SIGNATURE DATE