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PHONE 505-296-1332

2010 WYOMING BLVD. SUITE K
ALBUQUERQUE, NM 87112

PATIENT INFORMATION

Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Male ___ Female ___ Married ___ Single ___ DOB _____ Social
Security# _____

Phone (Home): _____ (Work): _____ Ext. _____ (Cell): _____

Street Address: _____ Apartment #: _____

City: _____ State: _____ Zip Code: _____

Occupation: _____ Employer: _____

Person to contact in case of an emergency: _____
Name Relationship

Emergency Contact's Phone Number: _____

Whom may we thank for referring you to our office? _____

Physician's Name: _____ Phone Number: _____

If you are filling out this form for another person, what is your relationship to this person? _____

Please explain why you have come to our office: _____

Insurance Information

Subscriber Name: _____ DOB _____

Subscriber SS#: _____ Group#: _____ Policy#: _____

Employer: _____

Insurance Company Name _____

Insurance Company Address: _____

This office does not have a contract with your insurance company. Patients who have dental insurance should remember that professional services are rendered to you, the patient, and not to the insurance company. You are financially responsible for all charges. By signing below, you authorize release of information relating to insurance claims and authorize payment to the dentist of the insurance benefits otherwise payable to you. If your account becomes delinquent, you will be responsible for the balance due, interest and collection costs.

Signature _____ Date _____

MEDICAL HISTORY

Are you presently under medical care? YES NO
 Explain _____
 Have you been treated by a physician within the last 12monthsYES NO
 Explain _____
 Have you ever had a major operation?YES NO
 Explain _____
 Have you had a serious illness or injury?YES NO
 Explain _____
 Are you presently taking any medications or drugs? YES NO
 Explain _____
 Are you ALLERGIC to any medicine, drug, food, metal or latex gloves?YES NO
 Explain _____
 Have you had adverse reactions to local anesthetics?YES NO
 Explain _____
 Have you ever had problems with dental treatment or prolonged bleeding after tooth extractions? YES NO
 Explain _____
 Are you pregnant or suspect pregnancy? YES NO

Read the medical conditions below. CIRCLE those that you have now and those you have had in the past.

- | | |
|-------------------------------------|---------------------------------|
| Heart disease or heart murmur | Lung problems or emphysema |
| Heart attack | Tuberculosis |
| Mitral valve prolapse | Asthma or sinusitis |
| Rheumatic fever | Arthritis or painful joints |
| High blood pressure | Kidney disease |
| Low blood pressure | Intestinal or stomach problems |
| Fainting spells or seizures | Mental health problems |
| Artificial joints | Artificial heart valve |
| Vascular grafts | Chest pain |
| Cancer treatment (x-ray/medication) | Heart pacemaker |
| Sexually transmitted disease | Thyroid problems |
| Hepatitis or liver disease | Neurological disorder |
| HIV or AIDS | Bleeding or blood problems |
| Stroke | Anemia |
| Leukemia | Diabetes |
| Drug addiction | Jaw joint click, pop or painful |

Any other problem not listed above: _____

I certify that I have read and understand the above, and that my answers are truthful to the best of my knowledge. My questions concerning the above have been answered to my satisfaction.

Patient Signature _____ Date _____

FOR OFFICE USE ONLY:

PULSE _____ BLOOD PRESSURE _____