Healthy Teeth Family Dentistry

10630 N 59th Avenue. Suite 101. Glendale. AZ 85304

Patient Information

Patient Name: _____ DOB: _____

SSN/Patient ID #: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____-_____ Home Cell Work Other

Email: _____

Sex: Male Female Marital Status: Single Married Other

Occupation: _____ Employer: _____

Employer Phone: _____

Spouse's Name: _____ DOB: _____

SSN#: _____

Occupation: _____

Phone: (_____) _____-_____ Home Cell Work Other

Spouse's Employer: _____

Spouse's Employer Phone: (_____) _____-_____

Whom may we thank for referring you? _____

Dental Insurance

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's DOB: _____ Subscriber's SSN #: _____

Insurance Company: _____

Group#: _____

Is patient covered by additional insurance? Yes No

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's DOB: _____ Subscriber's SSN #: _____

Insurance Company: _____

Group#: _____

Assignment and Release

I certify that I and/or my dependent(s) have insurance coverage with the company in which I have noted above. I assign Healthy Teeth Family Dentistry all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance submissions.

Signature of Patient or Parent/Guardian: _____

Relationship to Patient: _____ Date: _____

Dental History

Reason for today's visit:_____

Former Dentist:_____

City:_____ State:_____

Dates of last Dental visit:_____ X-rays:_____ Cleaning:_____

Health History

Physician's Name:_____ Date of last visit:_____

Do you wear contact lenses? Yes No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? Yes No

Circle "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	Yes	No	Emphysema	Yes	No	Radiation Treatment	Yes	No
Anemia	Yes	No	Epilepsy	Yes	No	Respiratory Disease	Yes	No
Arthritis, Rheumatism	Yes	No	Fainting or dizziness	Yes	No	Rheumatic Fever	Yes	No
Artifical Heart Valves	Yes	No	Glaucoma	Yes	No	Scarlet Fever	Yes	No
Artifical Joints	Yes	No	Headaches	Yes	No	Shortness of Breath	Yes	No
Asthma	Yes	No	Heart Murmur	Yes	No	Sinus Trouble	Yes	No
Back Problem	Yes	No	Heart Problems	Yes	No	Skin Rash	Yes	No
Bleeding abnormally with			Hepatitis Type_____	Yes	No	Special Diet	Yes	No
extractions or surgery	Yes	No	Herpes	Yes	No	Stroke	Yes	No
Blood Disease	Yes	No	High Blood Pressure	Yes	No	Swollen Feet or Ankles	Yes	No
Cancer	Yes	No	Jaundice	Yes	No	Swollen Glands	Yes	No
Chemical Dependency	Yes	No	Jaw Pain	Yes	No	Thyroid Problems	Yes	No
Chemotherapy	Yes	No	Kidney Disease	Yes	No	Tonsilitis	Yes	No
Circulartory Problems	Yes	No	Liver Disease	Yes	No	Tuberculosis	Yes	No
Congenital Heart Lesions	Yes	No	Low Blood Pressure	Yes	No	Tumor or growth on		
Cortisone Treatment	Yes	No	Mitral Valve Prolapse	Yes	No	head or neck	Yes	No
Cough, persistent or			Nervous Problems	Yes	No	Ulcer	Yes	No
bloody	Yes	No	Pacemaker	Yes	No	Venereal Disease	Yes	No
Diabetes	Yes	No	Psychiatric Care	Yes	No	Weight Loss	Yes	No

Women:

Are you pregnant? Yes No Are you nursing? Yes No Taking birth control pills? Yes No

Name of OB/GYN:_____

OB/GYN Phone: (_____)_____-_____ Due Date:_____

Allergies

Asprin	Yes	No	Local Anesthetic	Yes	No
Barbiturates (Sleeping pills)	Yes	No	Penicillin	Yes	No
Codeine	Yes	No	Sulfa	Yes	No
Iodine	Yes	No	Other_____		
Latex	Yes	No	_____		

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name:_____ Phone: (_____)_____-_____