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St. Thomas, VI 00802
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Patient Information

Today's Date: _____

Patient's Name: _____ Sex: [ ] M [ ] F Birth date: _____

SS#:_____ E-Mail Address: _____

Home phone: (_____) _____ Cell phone: (_____) _____ Alternate phone: (_____) _____

Mailing Address: _____ City: _____State:_____ Zip: _____

Patient's marital status: ____ Married ____ Widowed ____ Single _____ Minor ____ Separated ____ Divorced

Employer/School: _____ Employer/School Number: (_____) _____ Ext: _____

Spouse/Emergency Contact: _____ Phone: (_____) _____

Whom may we thank for referring you? _____

Responsible Party *(if patient is under the age of 18)*

Name of Person Responsible: _____ Birth date: _____ SS#:_____

Relation to Patient: _____ Cell Phone: (_____) _____ E-Mail Address: _____

Employer: _____ Work Phone: (_____) _____ Ext: _____

Insurance Information: Do you have Dental Insurance? Yes [ ] No [ ]

Name of Insurance Company: _____ Phone: _____

Name of Policy Holder: _____ Relation to Patient: _____

Birth Date: _____ SS#: _____ Employer: _____

Group#: _____ Subscriber/ Member ID: _____

Address: _____City: _____State: _____Zip:_____

Dental History

Reason for today's visit: _____ Date of last dental Care: _____

Please check appropriate answers:

[ ] Bad Breath
[ ] Bleeding gums
[ ] Clicking or popping jaw
[ ] Food collection between teeth
[ ] Grinding teeth
[ ] Loose teeth or broken fillings
[ ] Periodontal treatment
[ ] Sore or growths in your mouth
[ ] Sensitivity to hot
[ ] Sensitivity to sweets
[ ] Sensitivity when biting
[ ] Sensitivity to cold

How often do you floss? _____ How often do you brush? _____

Medical History

Have you had any serious illnesses or operations? _____If yes (describe):_____
Have you ever had a blood transfusion? YES (____) No: (____) If yes, give approximate date_____
(**Women)** Are you pregnant? _____

Please check appropriate answers:

[ ] Anemia
[ ] Arthritis, Rheumatism
[ ] Artificial Heart Valves
[ ] Artificial Joints, Pains etc
[ ] Asthma
[ ] Back Problems
[ ] Bleeding Abnormally
[ ] Blood Disease
[ ] Cancer
[ ] Chemical Dependency
[ ] Chemotherapy
[ ] Venereal Disease
[ ] Congenital Heat Lesions
[ ] Cortisone Treatments
[ ] Cough, Persistent
[ ] Cough up Blood
[ ] Diabetes
[ ] Epilepsy
[ ] Fainting
[ ] Glaucoma
[ ] Headaches
[ ] Heart Murmur
[ ] Heart Problems
[ ] Circulatory Problems
[ ] Hepatitis
[ ] Hernia Repair
[ ] High Blood Pressure
[ ] HIV? AIDS
[ ] Jaw Pain
[ ] Kidney Disease
[ ] Liver Disease
[ ] Mitral Valve Prolapsed
[ ] Pacemaker
[ ] Radiation Treatment
[ ] Respiratory Disease
[ ] Hemophilia
[ ] Scarlet Fever
[ ] Stroke
[ ] Skin Rash
[ ] Shortness of Breath
[ ] Swelling of Feet
[ ] Thyroid Problem
[ ] Tobacco Habit
[ ] Tonsillitis
[ ] Tuberculosis
[ ] Ulcer
[ ] Rheumatic Fever

List Medication you are currently taking:

_____

_____

_____

Allergies:

_____

_____

_____

Authorization and Release

To the best of my knowledge, the above information is complete and correct. I understand that is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I certify that I, and/or my dependent(s), have insurance coverage with (*Name of Insurance Company)*_____ and assign directly to Dr. _____all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. The above named dentist may use my health care information and may disclose such information to the above named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits. This consent will end when the current treatment plan is completed or one year from date signed below.

_____ _____ _____
Signature of Patient, Parent/Guardian | Relation to Patient | Date