Bay Dental Office

(440) 899-7950

Cell phone # ____________________
E-Mail address ____________________
How did you hear about us? ____________________

Patient Name: ____________________ Birth date: ____________________
Patient's address:
City: ____________________ State: ________ Zip: ________ Phone: (   ) ____________

Patient's employer: ____________________ Employer's Address: ____________________
Employer's Phone: (   ) ____________ Soc. Sec No.: ____________ Years worked: ____________

Marital status: (   ) Single (   ) Married (   ) Separated (   ) Divorced (   ) Widowed
Spouse's Name: ____________________ Soc. Sec No.: ____________
Spouse's Employer: ____________________ Employer's Phone: (   )____________
In Case of Emergency Contact Name: ____________________ Phone: (   ) ____________

IF SPOUSE OR GUARDIAN IS LIABLE FOR ACCOUNT FILL IN THE FOLLOWING
Responsible Party's Name: ____________________ Birth date: ____________
Address: ____________________ Phone (   ) ____________
Party's Employer: ____________________ Years Employed? ________ SS# ____________
Dental Insurance? (   ) Yes (   ) No
Name of Company: ____________________
Family Doctor's Name: ____________________ Phone (   ) ____________ Last Physical: ____________

If you have or have had any of the following, please check

( ) Any Heart Problems	( ) Hepatitis (Date: ____________)	( ) Pacemaker
( ) High Blood Pressure	( ) Hepatitis Still Active?	( ) Ulcer
( ) Low Blood Pressure	( ) Stroke	( ) Anemia
( ) Circulatory Problems	( ) Previous Surgery	( ) Arthritis
( ) Nervous Problems	( ) Contact Lenses	( ) Asthma
( ) Radiation Treatments	( ) AIDS	( ) Diabetes
( ) Heart Murmur	( ) Rheumatic Fever	( ) Epilepsy
( ) Excessive Bleeding	( ) Scarlet Fever	( ) Tonsillitis
( ) Allergies to Anesthetics	( ) Sinus Problems	( ) Tuberculosis

I AM ALLERGIC TO THE FOLLOWING MEDS: ____________________
____
Are you pregnant? ____________ Last Dental Exam? ____________ What was done? ____________
Are you having discomfort at this time? ____________________ Bleeding Gums? ____________
Have you ever had gum treatment? ____________ When? ____________
I am Currently taking the flowing medications:

MEDICATION REASON TIMES PER DAY

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________
2.____________________

I certify that I have answered all the questions to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information regarding my treatment or my child's treatment to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist otherwise payable to me. I understand that my dental insurance may pay less than the actual bill. I agree to be responsible for the payment of all services.

Signature: ____________________ Date: ____________