BAY DENTAL
OFFICE

PATIENT _____
Phone _____ DOB _____
Address _____
City _____ State ___ Zip _____
Employer _____
Address _____
Phone _____ Yrs Worked _____
Social Security _____
Marital Status: ○Single ○Married ○Separated ○Divorced ○Widowed
Spouse's Name _____
Spouse's Employer _____
Social Security _____
Employer's Phone _____
Emergency Contact _____
Emergency Contact's Phone _____

IF RESPONSIBLE PARTY IS LIABLE

Name _____
Phone _____ DOB _____
Address _____
City _____ State ___ Zip _____
Employer _____
Address _____
Phone _____ Yrs Worked _____
Social Security _____

Dental Insurance? ○Yes ○No
Company Name _____
Family Doctor _____
Phone _____ Last Physical _____

IF YOU HAVE/ HAD ANY OF THE FOLLOWING, PLEASE CHECK:

○ ANY Heart Problems	○ Excessive Bleeding	○ Contact Lenses	○ Ulcer
○ High Blood Pressure	○ HPV	○ AIDS	○ Anemia
○ Low Blood Pressure	○ Anesthetic Allergy	○ Rheumatic Fever	○ Arthritis
○ Circulatory Problems	○ Hepatitis (Date ____)	○ Scarlet fever	○ Asthma
○ Nervous Problems	○ Hepatitis - Still Active?	○ HPV Vaccine	○ Diabetes
○ Radiation Treatments	○ Stroke	○ Sinus Problems	○ Tonsillitis
○ Heart Murmur	○ Previous Surgery	○ Pacemaker	○ Tuberculosis

Pregnant? _____ Last dental exam _____ What was done? _____
Current discomfort? _____ Bleeding Gums? ____ Have you ever had treatment? ____ When? _____

MEDICATIONS I AM ALLERGIC TO _____

MEDICATIONS I AM CURRENTLY TAKING REASON FREQUENCY

1. _____
2. _____
3. _____
4. _____
5. _____

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 _____