Patient Information

Patient Name:_____ Date of Birth: _____
Last, First MI (Preferred Name)

Health Information

Have you ever had or have any of the following? Please check those that apply:

□ AIDS	□ Epilepsy	□ Kidney Disease	□ Tuberculosis
□ Allergies	□ Excessive Bleeding	□ Liver Disease	□ Tumors
□ Anemia	□ Fainting	□ Mental Disorders	□ Ulcers
□ Arthritis/Rheumatism	□ Glaucoma	□ Nervous Disorders	□ Artificial Joints
□ Artificial Joints	□ Hay Fever	□ Pacemaker	□ Thyroid Disease
□ Asthma	□ Head Injuries	□ Radiation Treatment	**Medications you are taking:**
□ Blood Disease	□ Heart Disease	□ Respiratory Problems	□ _____
□ Cancer	□ Heart Murmur	□ Sinus Problems	□ _____
□ Diabetes	□ Hepatitis	□ Stomach Problems	□ _____
□ Dizziness	□ High Blood Pressure	□ Stroke	

Women Only: Please check all that apply: □ Pregnant/Due Date: _____ □ Nursing □ Taking Oral Contraceptives

Are you allergic to or have had any reactions to the following? □ None □Penicillin or any other antibiotic □Sulfa Drug □Barbiturates □Sedatives □Iodine □Aspirin □Latex □Other (Please List):_____

- **Have you seen a dentist in the last year?** If so:
  Dr. Name: _____Phone: _____
  Address: _____
- **Have you ever experienced any of the following:** □Problems in your jaw □Clicking □Difficulty in opening or closing

  Do you like your smile? □Yes □No
- Have you ever had any complications following dental treatment? □Yes □No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past five years? □Yes □No
  If yes, please explain: _____
- Are you now under the care of a physician? □Yes □No
  If yes, please explain: _____

  Name of Physician: _____ Phone: _____
- Do you use any of the following tobacco products? □Cigarettes □Pipe or Cigar/Dip or Chew

Emergency Contact: _____
Preferred Hospital: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health history, I will inform the doctors at the next appointment without fail.

I also give permission to the doctor to do an exam and give me a diagnosis of any problem I am having. If any x-rays need to be taken I give the doctor permission to do so.

Signature of patient, parent or guardian: _____ **Date:** _____

Welcome – Fiesta Dental

Patient Information

Name: _____ Date: _____

Family Status: _____ Birth Date: _____ SS#: _____ Driver License:_____

Address: _____
Street Apartment#

_____
City State Zip Code

Email: _____Phone: Home _____ Work: _____ Ext:_____

Cell Phone: _____Employer:_____

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

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment is due in full at each appointment. □Cash □Personal Check □Credit card □I wish to discuss payment policy.

Responsible Party Information

□ **Check box if same as above**

Name: _____

Status: _____ Birth Date: _____ Social Security: _____Drivers License:_____

Address:_____
Street Apartment #

_____
City State Zip Code

Email: _____ Phone: Home:_____ Work: _____Ext:_____

Cell Phone: _____ Employer: _____Employer Phone:_____

Insurance Information

Primary

Name of Insured: _____ Relationship to patient: _____

Insured's Birth Date: _____ ID#: _____ Group#: _____

Insured's Address: _____
Address City State Zip Code

Insured's Employer Name: _____

Insurance Plan Name and Address: _____

_____ Phone:_____

Secondary

Name of Insured: _____ Relationship to patient: _____

Insured's Birth Date: _____ID#: _____ Group#: _____

Insured's Address: _____
Address City State Zip Code

Insured's Employer Name: _____

Insurance Plan Name and Address: _____ Phone: _____