WELCOME TO OUR OFFICE

DATE: _____

PATIENT NAME: (first, middle, and last) _____

HOME ADDRESS: _____

CITY: _____STATE: _____ZIP: _____

HOME PHONE: _____CELL: _____WORK: _____

EMAIL ADDRESS: _____

BIRTH DATE: _____SEX: _____Female _____Male

MARITAL STATUS: _____Single _____ Married _____Divorce _____Widow(er)

EMPLOYER: _____OCCUPATION: _____

PATIENT SOCIAL SECURITY #: _____

HAS ANY MEMBER OF YOUR FAMILY BEEN TREATED IN OUR OFFICE PREVIOUSLY? _____yes _____no

IF YES, WHO? _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

INSURANCE INFORMATON

INSURANCE COMPANY: _____GROUP: _____

SUBSCRIBER'S NAME: _____SOCIAL SECURITY #: _____

BIRTH DATE: _____RELATIONSHIP TO PATIENT: _____

WE WILL NEED TO MAKE A COPY OF YOUR DENTAL INSURANCE CARD

IF PATIENT IS A MINOR, OR HAS A POWER OF ATTORNEY, PLEASE FILL OUT THE FOLLOWING INFORMATION:

NAME OF RESPONSIBLE PARTY AND RELATIONSHIP: _____

ADDRESS: _____

PHONE: _____

1. I authorize Dr. Horton to perform all recommended treatment mutually agreed upon by me, and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that Dr. Horton choose and employ such assistance as deemed fit to provide recommended treatment.
2. I understand that it is my responsibility to advise Dr. Horton's office of any changes in the information contained on this form.

Signature: _____Date: _____

HEALTH HISTORY

Patient Name: _____Date_____

General Health: Good_____ Fair_____ Poor_____

Physician's Name_____

Last Complete Physical_____

Are you currently on any medications? Yes_____ No_____

If YES, please list medications and purpose:

_____

_____

Are You Allergic to: Penicillin_____ Codeine_____ Local Anesthetic_____ Latex_____ Other _____

Do you now have or have you ever had any of the conditions listed below (check YES or NO)

Abnormal Blood Pressure	Yes___ No___		
Anemia	Yes___ No___	Joint Replacement	Yes___ No___
Arthritis	Yes___ No___	Hip____ Date_____ Knee_____ Date_____	
Asthma	Yes___ No___	Pacemaker	Yes___ No___
Bleeding Problems	Yes___ No___	Prosthetic Heart Valve	Yes___ No___
Blood Diseases	Yes___ No___	Radiation Treatment	Yes___ No___
Cancer	Yes___ No___	Respiratory Problems	Yes___ No___
Diabetes	Yes___ No___	Seizures	Yes___ No___
Emphysema	Yes___ No___	Stroke / TIA's	Yes___ No___
Glaucoma	Yes___ No___	Thyroid Problems	Yes___ No___
Heart Disease	Yes___ No___	Transplant Patient	Yes___ No___
Heart Murmur	Yes___ No___	Tuberculosis	Yes___ No___
Hepatitis A, B, or C	Yes___ No___	Tumors / Biopsies	Yes___ No___
HIV Positive / Aids	Yes___ No___		

Do you take any of the following medications:

Bisphophonate: Yes___ No___ Coumadin/Plavix: Yes___ No___ Daily Aspirin: Yes___ No___

Other Medical Conditions Not Listed Above?_____

(WOMEN ONLY) Are You Currently Pregnant? Yes____ No____ How Far Along?_____

OFFICE USE ONLY:

Updated: _____ Date_____

Updated: _____ Date_____

Updated: _____ Date_____