Patient's Name: _____ Patient's Birth Date: _____

(If child)

Father's Name _____ DOB: _____

Mother's Name _____ DOB: _____

Mailing Address: _____City _____ Zip _____

Home Phone # _____Cell Phone # _____ Message # _____

Employer: _____ Work Phone # _____

Social Security No. _____

Spouse's Name: _____ DOB: _____

Employer: _____ Work Phone # _____

Social Security No: _____

Referred by: _____

Email _____

Private: _____ Insurance: _____

INSURANCE INFORMATION

Primary Insurance

Name of insured: _____ Social Security No./ID # _____
Insurance Co. _____ Group #: _____

Secondary Insurance

Name of insured: _____ Social Security No./ID# _____
Insurance Co. _____ Group # _____

Credit Information

Responsible Party: _____

I agree to pay all fees on the date of service unless specific financial arrangements have been made. I understand that payment is my obligation regardless of insurance or any other third-party involvement. My signature below releases assignment of Insurance Benefits to Blue Hearts Dental.

Signature: _____ Date: _____

Patient Name: _____ Date: _____

Chief Dental Complain: _____
Date of Last Dental Visit and X-rays: _____ Name of Medical Dr. _____

Are you taking any medications at this time? Please list:

_____

DO YOU HAVE A MEDICAL CONDITION WHICH REQUIRES PRE-MEDICATION PRIOR TO DENTAL WORK?

_____

Have you had any difficulties with local anesthesia? Please explain:

_____

HAVE YOU EVER BEEN DIAGNOSED WITH OR TREAT FOR:

	NO	YES	Explain
Heart Murmur----------	□	□	_____
Rheumatic Fever----------	□	□	_____
Pace Maker----------	□	□	_____
Valve Replacement----------	□	□	_____
Heart Attack----------	□	□	_____
By-Pass Surgery----------	□	□	_____
Stroke----------	□	□	_____
Abnormal Blood Pressure----------	□	□	_____
Ulcers----------	□	□	_____
Tuberculosis or lung disease----------	□	□	_____
Diabetes----------	□	□	_____
Anemia----------	□	□	_____
Cancer----------	□	□	_____
Venereal Disease----------	□	□	_____
Asthma----------	□	□	_____
Hepatitis----------	□	□	_____
Arthritis----------	□	□	_____
Joint Replacement----------	□	□	_____
HIV positive (Aids)----------	□	□	_____
Cocaine or Street Drug User----------	□	□	_____
Seizures----------	□	□	_____

ARE YOU ALLERGIC TO:

Penicillin----------	□	□
Codeine----------	□	□
Local Anesthesia----------	□	□
Sulfa----------	□	□
Latex----------	□	□
Are you subject to prolonged bleeding?	□	□
Are you pregnant? ----------	□	□

Date Due _____

Other medical complications? _____

Have you ever been involved with dental/medical legal activity? Yes_____ No____