Prestige
DENTAL CENTERS

Date _____

SS # _____

Patient Name_____

_____

Home Phone (_____)_____

Work (_____)_____

Cell (_____)_____

Address _____

City_____

State _____ Zip _____

Email _____

Sex: ☐ M ☐ F

Birthdate _____ Age _____

☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated

☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer / School _____

Employer / School Phone (_____)_____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you?

_____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Primary Insurance Co. _____

ID # _____ Grp #_____

Subscriber's Name _____

Birthdate _____ SS # _____

Relationship to Patient _____

Secondary insurance_____

Insurance Co. _____

Subscriber's Name_____

Birthdate_____ SS#_____

ID#_____ Grp#_____

In Case of Emergency, Contact

Specify someone who does not live in your household

Name _____

Relationship _____

Phone (_____)_____

Allergies

☐ Aspirin
☐ Codeine
☐ Dental Anesthetics
☐ Erythromycin
☐ Jewelry
☐ Latex
☐ Metals
☐ Penicillin
☐ Tetracycline

Other_____

_____

_____

Health History

Please check to indicate if you have had any of the following:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding abnormally, with extractions or surgery
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, persistent or bloody
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting or dizziness
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis Type _____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Feet of Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or growth on head or neck
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Weight Loss, unexplained

Do you wear contact lenses? ☐Yes ☐No

Do you smoke? ☐ Yes☐ No

Women:

Are you Pregnant? ☐Yes ☐No Due date_____

Taking birth control pills? ☐ Yes ☐ No

Are you nursing? ☐Yes ☐No **Reason for visit**_____

Medications

Please list any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

_____

Pharmacy Name_____

Phone (_____)_____