HORIZON DENTAL

Name: _____ ☐ Male ☐ Female
Last First Middle

Birth Date: _____ / _____ / _____ Age: _____ Social Security #: _____ (For Insurance/ Office Use ONLY)

Home Address: _____
Street/P.O. Box City State Zip

Home Phone #: _____ Cell #: _____ Work #: _____

Are you an existing patient? ☐ Yes ☐ No If not, whom may we thank for referring you? ☐ Another patient Name: _____
☐ Dental Office ☐ Drive by ☐ Phonebook ☐ School ☐ Work ☐ Other

Employer: _____ How Long there? _____ Occupation: _____

Employer's Address: _____
Street/P.O. Box City State Zip

SPOUSE OR EMERGENCY CONTACT INFORMATION

His / Her Name: _____ Birth Date: _____/_____/_____ Relationship: _____

Home Phone #: _____ Work #: _____ Ext.: _____

MEDICAL HISTORY / HEALTH INFORMATION

Have you ever had any of the following? If so, please check the box:

☐ Acid Reflux	☐ Dizziness	☐ Hepatitis: A B C	☐ Pacemaker	☐ Tobacco Use
☐ Alcohol Abuse	☐ Drug Abuse Meth / Other	☐ High Blood Pressure	☐ Psychiatric Problems	☐ Tuberculosis (TB)
☐ Artificial Joints	☐ Emphysema	☐ HIV+ / Aids	☐ Radiation Treatment	☐ Tumors
☐ Artificial Valves	☐ Epilepsy	☐ Kidney Problems	☐ Respiratory Problems	☐ Ulcers
☐ Asthma	☐ Excessive Bleeding	☐ Liver Disease	☐ Seizures	☐ Other
☐ Blood Disease	☐ Fever Blisters	☐ Low Blood Pressure	☐ Sinus Problems	
☐ Cancer	☐ Glaucoma	☐ Lupus	☐ Stomach Problems	
☐ Chemotherapy	☐ Heart Attack	☐ Nervous Disorder	☐ Stroke	
☐ Diabetes: Type 1 / 2	☐ Heart Disease	☐ Osteoporosis	☐ Thyroid Disorder	

For Women: Are you Pregnant? ☐ Unsure ☐ Yes ☐ No Week #: _____

Please list any serious medical condition(s) that you have experienced: _____

_____

Please list all prescription medications that you are currently taking. If none, please check the box → ☐ NONE

_____

_____

_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING

☐ Aspirin	☐ Codeine	☐ Erythromycin	☐ Latex	☐ Sedatives	☐ Tetracycline
☐ Barbiturates	☐ Dental Anesthetics	☐ Jewelry / Metals	☐ Penicillin	☐ Sulfa Drugs	☐ Other _____

How would you rate your fear of dental treatment? ☐ Low ☐ Moderate ☐ High

AUTHORIZATION

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I understand that I am responsible for payment of services rendered. As a courtesy, we will file your dental insurance as an out of network provider.

_____ Date: _____
Signature of patient, parent / guardian