T E R R I L . A L A N I , D . D . S .

COMPREHENSIVE GENERAL AND COSMETIC DENTIST

DATE _____

PATIENT'S NAME: _____

PREFERRED NAME TO BE CALLED: _____
DATE OF BIRTH: _____
S.S. #: _____-_____-_____ **Cell Phone #:** _____
SPOUSE'S NAME: _____ **Email:** _____
HOME PHONE #: (____) _____
HOME ADDRESS: _____
PREVIOUS ADDRESS, if less than three years: _____
_____

* **MARITAL STATUS: SINGLE MARRIED DIVORCED SEPERATED**
* **PATIENT EMPLOYED BY:** _____
  - **Occupation:** _____
  - **Company's Address:** _____
    _____
  - **Company's Phone #: (_____)** _____
* **SPOUSE EMPLOYED:** _____
  - **Occupation:** _____
  - **Company's Address:** _____
    _____
  - **Company's Phone #: (_____)** _____

Name, address, and phone of nearest friend/relative not living in household:
Name: _____
Address: _____
Phone #:(_____) _____

* **Please tell us how you were referred to our office:** _____
* **How will this account be paid? CASH** _____
  CHECK _____
  CREDIT CARD _____
* **Do you have <u>dental</u> insurance that may cover any part of our services?** _____
  If YES, please complete the following:
  - **Insured name:** _____
  - **Social security #:** _____-_____-_____
  - **Company employed by:** _____ **Phone #: (_____)** _____

Insurance billing is provided as a service to our patients, but you are ultimately responsible for the payment of your account. We reserve the right to require full payment if your insurance company has not paid within ninety (90) days.

* **Purpose of today's appointment:** _____

* **Last dental examination:** _____

* **Last medical examination:** _____

* **Have you been hospitalized in the last (5) years? YES NO**
  If YES, Reason: _____

* **WOMEN: Are you pregnant? YES NO**

* **Do you have or have you ever had, please check or circle:**

____ Anemia	____ Alcohol dependency
____ Diabetes	____ Drug dependency
____ Epilepsy	____ Hepatitis
____ Rheumatic fever	____ Kidney disease
____ Heart	____ TMJ
____ Angina	____ Abnormal blood pressure
____ Abnormal heart condition	High _____ Low _____
____ Mitral valve prolaspe	____ Are you allergic to:
____ Stroke	Penicillin: yes no
____ Abnormal bleeding from a cut	Local anesthetic: yes no
____ Venereal Disease	Medication (drugs): yes no
____ Cancer	
____ AIDS	

* **Indicate which <u>drugs</u> or <u>medications</u> you are allergic to:** _____
_____

* **Are you presently taking any medications? ____. If so, for what?** _____
_____

* **Are you receiving any health• care? yes no. If so, what?** _____
_____

* **Name of physician:** _____
  Phone #: (_____) _____
  Address: _____

I certify that all information given on this form is accurate to the, best of my knowledge.

Signed: _____ **Date:** _____