Welcome to HORIZONS DENTAL

Last Name: _____ Legal First Name: _____ M.I. ___ Preferred Name: _____

Home Address: _____ City: _____ State: _____ Zip_____

Home Phone: (___) _____ Work Phone: (___) _____ Ext: _____ Cell Phone: (___) _____

E-Mail Address_____@_____ ☐ Male ☐ Female

Drivers License #: _____ ☐ Single ☐ Married ☐ Divorced ☐Widow

DOB: _____/_____/_____ Age: _____ SS#:_____-____-_____

Employer: _____How Long? _____ Occupation: _____

Employer's Address: _____City: _____ State:_____ Zip_____

Spouse's Name: _____ Who referred you to our office? _____

Emergency Contact _____ Relation: _____

Home Phone: (___) _____Work Phone: (___) _____ Ext: _____ Cell Phone: (___) _____

Primary Dental Insurance Coverage

Subscriber Name: _____ DOB: ___/___/___ SS#:_____

ID# _____ Group #: _____ Insured's Employer:_____

Insurance Company Name: _____ Phone: (_____) _____

Secondary Dental Insurance Coverage

Subscriber Name: _____ DOB: ___/___/___ SS#:_____

ID# _____ Group #: _____ Insured's Employer:_____

Insurance Company Name: _____ Phone: (_____) _____

OVER

MEDICAL HISTORY

***Do you have a medical condition that requires antibiotic pre-medication before dental treatment? ☐ Yes ☐ No**

Name of Medical Doctor _____ phone: _____

Please list **all** medications you are currently taking _____

_____

Do you use tobacco? ☐ Yes ☐ No If so, how often? _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

- ☐ AIDS/HIV+
- ☐ Alcohol/Drug Abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Bones/Joints
- ☐ Artificial Valves
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Problems
- ☐ Blood Thinners
- ☐ Cancer/Tumors
- ☐ Cosmetic Surgery
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches (Severe)
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Surgery
- ☐ Heart Murmur
- ☐ Hepatitis A, B, or C
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation/Chemotherapy
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ TMJ/TMD
- ☐ Tuberculosis TB
- ☐ Ulcers
- ☐ Venereal Disease

Please list any surgeries or medical conditions you have had: _____

_____

Are you allergic to any of the following? ☐ Latex ☐ Penicillin/Amoxicillin ☐ Tetracycline ☐ Sulfa

☐ Dental anesthetics ☐ Foods: _____ ☐ Others: _____

Pharmacy Name & Location _____

For Women: Are you taking Birth Control Pills? ☐ Yes ☐ No How many children have you had? _____

Are you Pregnant? ☐ Yes ☐ No If yes how many weeks? _____ Due Date: _____ Are you nursing? ☐ Yes ☐ No

Signature _____ Date _____/_____/_____

☐ Parent or Guardian ☐ Spouse