



Patient Name:		<input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:
If Minor – Responsible Party's Name:			
Address:			
City:		State:	Zip Code:
Home Phone:	Work Phone:		Cell Phone:
Email:		Preferred Method of Contact: <input type="checkbox"/> <input type="checkbox"/> Email	
Emergency Contact:		Relationship:	Phone:
Responsible Party and/or Primary Insurance Information: (Please notify us if there is secondary dental coverage)			
Relationship to Patient: <input type="checkbox"/> Self (if self, skip to insurance info) <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other:			
Responsible Party's Name or Policy Holder's Name:			
Date of Birth:	Social Security Number:		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other
Address:			
City:		State:	Zip:
Home Phone:	Work Phone:		Cell Phone:
Employer:		Occupation:	
Insurance Plan Name:		Insurance Group Number:	
Insurance Plan Phone Number:		Insurance Subscriber ID Number:	
MEDICAL UPDATE			
Name of Your Physician:		(If you do not have a physician, please write none.)	
Last Exam:	Phone Number:		
Women: Are you pregnant or think you could be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		Expected Delivery Date:	
Are you taking birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No		Nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you under a doctor's care now? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, for what reason?			
Current use of any tobacco product? <input type="checkbox"/> None <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigar <input type="checkbox"/> Pipe <input type="checkbox"/> Chewing tobacco <input type="checkbox"/> Other			
Because of anesthetic, we need to know if you currently or have used any street/illicit drugs. If so, please list:			



Patient Name:

Are you taking any pills, medications or prescription drugs? Yes No

Please List:

Do you have or have you ever been treated for any of the following? Please check all that apply.

<input type="checkbox"/> AIDS/HIV <input type="checkbox"/> Acid Reflux / GERD <input type="checkbox"/> Allergy to <input type="checkbox"/> Medications <input type="checkbox"/> Anesthetic <input type="checkbox"/> Seasonal allergies List: _____ <hr/> <input type="checkbox"/> Angina / Chest pain <input type="checkbox"/> Anti-depression treatment <input type="checkbox"/> Arthritis / Rheumatism Type: _____ <hr/> <input type="checkbox"/> Artificial heart valves Date: _____ <hr/> <input type="checkbox"/> Artificial joints Date: _____ <hr/> <input type="checkbox"/> Aspirin treatment / Blood thinner <input type="checkbox"/> Asthma / Inhaler <input type="checkbox"/> Blood disease <input type="checkbox"/> Bruise easily <input type="checkbox"/> Cancer <input type="checkbox"/> Chemotherapy / Radiation therapy <input type="checkbox"/> Chronic cough	<input type="checkbox"/> Cold sores / Fever blisters <input type="checkbox"/> Cortisone medicine <input type="checkbox"/> Diabetes <input type="checkbox"/> Diet (special / restricted) <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy / Convulsions <input type="checkbox"/> Excessive bleeding <input type="checkbox"/> Fainting / Dizzy spells <input type="checkbox"/> Glaucoma <input type="checkbox"/> Hay fever / Allergy / Hives <input type="checkbox"/> Heart (disease, attack, or surgery) <input type="checkbox"/> Heart murmur <input type="checkbox"/> Hemophilia <input type="checkbox"/> Hepatitis: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> High blood pressure or <input type="checkbox"/> Low blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Hormone replacement treatment <input type="checkbox"/> Kidney trouble <input type="checkbox"/> Latex sensitivity <input type="checkbox"/> Liver disease / Yellow jaundice <input type="checkbox"/> Migraines <input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Nervous / Anxious <input type="checkbox"/> Neurological disorders <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Pacemaker / Defibrillator <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Psychiatric / Psychological care <input type="checkbox"/> Respiratory Problems <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Sickle Cell disease <input type="checkbox"/> Seizures <input type="checkbox"/> Sinus problems <input type="checkbox"/> Sexually transmitted diseases <input type="checkbox"/> Special Needs Type: _____ <hr/> Functions at age: _____ <hr/> <input type="checkbox"/> Stent (brain or spine) <input type="checkbox"/> Stroke <input type="checkbox"/> Substance abuse <input type="checkbox"/> Swollen ankles <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Tumors <input type="checkbox"/> Ulcers <input type="checkbox"/> Use of CPAP machine / Oral sleep device
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Consent for Services/Assignment of Benefits:

After my exam, I authorize the doctor to perform the necessary treatment as needed. I authorize the release of any information relating to dental treatment to third party payers and/or other health practitioners for myself or my dependents by Spring Valley Dental Group / provider. I authorize my doctor to submit claims to be submitted for my dependents or myself. I understand that all insurance payments will be made directly to the doctor, unless otherwise specified by me.

I have read the above conditions of treatment and agree to their contents.

Signature of Patient, Parent or Guardian:

Date: