ALL PATIENTS:

Do you have any discomfort or other dental concerns?

_____

_____

Is there anything that you would like to discuss with the doctor or that we should know to make your appointment more comfortable?

_____

_____

Do you have any need for pre-medication? YES NO

Pre-Med Pharmacy name and number

_____

Is Patient allergic to penicillin? YES NO

Do you have dental insurance? YES NO

If yes, get the following information:

Name of insured person _____

Relationship to patient _____

Insured's Employer _____

Working Number _____

SSN and DOB of insured _____ Tel. No._____

Ins. Co. Name _____ Tel. No. _____

Ins. Co. Address

_____

Do mornings or afternoons work best? AM PM

Best day of the week for an appointment?

_____

Reason for not scheduling

_____