Date: _____ e-mail address _____

Patient Name: _____ Soc. Sec. No. _____
Address: _____ Home Tel. No. _____
City: _____ State: _____ Zipcode: _____ Bus. Tel. No. _____
Birthdate: _____ Age: _____ Height: _____ Weight: _____

Occupation: _____ Cell Phone No. _____
Employer: _____
Work Address _____

Marital Status _____ Spouses Bus Address: _____
Spouse's Name _____ Spouse's Bus. Tel No. _____
Spouses Occupation: _____ Spouse's Soc. Sec. No. _____
Spouses Employer: _____ Spouse's Birthdate. _____

Nearest relative not living with you who we may contact in case of an emergency?
Name: _____
Address: _____
Phone: _____

Dental Ins Co. _____
Group No. _____
ID No. _____

Spouse's Dental Ins. Co. _____
Group No. _____
ID No. _____

I hereby authorize payment of the dental benefits otherwise payable to me directly to Dr. Alan Timko.

Signature: _____

Your Dentist's Name: _____
Your Dentist's Address: _____
Your Dentist's Phone No. _____

Your Physician's Name: _____
Your Physician's Address: _____
Your Physician's Phone No.: _____

Who may we thank for referring you to our office?
Name: _____
Address: _____

Who will be financially responsible for this bill? _____

I understand that I am ultimately responsible for any and all fees incurred and for the cost of recovery.

Signature: _____

How would you describe your present state of health? [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Have you ever been hospitalized? [ ] Yes [ ] No

Have you been under a doctor's care during the past two years? [ ] Yes [ ] No

Do you take any kind of drugs, medications, (prescription or non-prescription), herbs, vitamins, etc..? [ ] Yes [ ] No

Do you have any allergies? [ ] Yes [ ] No

Have you had excessive bleeding that required special treatment? [ ] Yes [ ] No

Do you have any of the following?

[ ] persistent cough	[ ] fatigue	[ ] loss of appetite
[ ] unexplained weight loss	[ ] yeast infections	[ ] diarrhea
[ ] swollen lymph glands	[ ] night sweats	[ ] fever

Is there a history of diabetes in your family? [ ] Yes [ ] No

Are you required to restrict your work or activity in any way? [ ] Yes [ ] No

Are you on a special or restricted diet of any kind? [ ] Yes [ ] No

Have you ever had a problem with drug or alcohol abuse? [ ] Yes [ ] No

Have you ever been refused as a blood donor? [ ] Yes [ ] No

Check any of the following you may have had:

[ ] Heart trouble	[ ] Mitral valve prolapse	[ ] Aids	[ ] Oral candidiasis
[ ] Congenital heart lesions	[ ] Glaucoma	[ ] Tuberculosis	[ ] Joint replacement prosthesis
[ ] Heart murmur	[ ] Hepatitis	[ ] Asthma	[ ] Hairy leukoplakia
[ ] Heart surgery	[ ] Diabetes	[ ] Cancer	[ ] Kaposi's sarcoma
[ ] Rheumatic fever	[ ] Jaundice	[ ] Epilepsy	[ ] Cold sores
[ ] Cardiac pacemaker	[ ] Psychiatric care	[ ] Arthritis	[ ] Sinus trouble
[ ] Heart valve Prosthesis	[ ] Kidney disease	[ ] Stroke	[ ] Venereal disease
[ ] High/low blood pressure	[ ] Persistent cough	[ ] Eating disorder	[ ] Recurrent mouth ulcers
[ ] Thyroid problems	[ ] Trauma/broken bones	[ ] Eye trouble	[ ] Osteoporosis

Have you ever had a blood transfusion? [ ] Yes [ ] No

Have you ever taken the appetite suppressants fen-phen? [fenfluramine (Pondimin), or dexfenfluramine (Redux)]? [ ] Yes [ ] No

Has your physician/dentist ever told you, that you should take antibiotics before **every** dental treatment? [ ] Yes [ ] No

Have you had a recent onset of respiratory problems like coughing or difficulty breathing? [ ] Yes [ ] No

Have you traveled internationally in the last 10 days? [ ] Yes [ ] No

Have you come in contact with a SARS patient in the past 10 days? [ ] Yes [ ] No

Do you currently have a fever? [ ] Yes [ ] No

Do you have any disease or condition not listed above that you feel we should know about? [ ] Yes [ ] No

Patient signature: _____ Date: _____