Welcome to

John Sauer's Dental Office

Name: (First)_____(MI)_____(Last)_____

Address:_____City:_____State:_____Zip:_____

Birthdate:_____Email:_____

Social Security #:_____-_____-_____

Home Phone:_____Cell Phone:_____

Work Phone:_____

Circle Appropriate: Minor Single Married Separated Widowed

Patient's or Parent's/Guardian's Employer:_____

Employer's address:_____City:_____State:_____Zip:_____

Employer's phone number:_____

Who referred the patient to our office?:_____

Insurance Information

Name of Insured_____Birthdate_____Relationship to Patient:_____
Insurance Co.:_____ID #:_____
Group #:_____Name of Employer:_____

Medical History

Have you ever had any of the following?

__Heart Murmur	**__ Circulation Problems**	**__ Cancer**
__Artificial Heart Valves or Joints	**__ Blood Diseases**	**__ Seizures**
__Rheumatic Fever	**__ Asthma**	**__ Nerve Problems**
__Mitral Valve Prolapse	**__Other Respiratory Disease**	**__ Kidney Problems**
__Heart Attacks	**__Diabetes**	**__ Stroke**
__Blood Pressure Problems	**__ Hepatitis or Liver Problems**	**__ Thyroid Disease**

Do you have an drug Allergies or have you ever had an adverse reaction to any medication?____ If so, what_____

List Current Medications:_____

(Women) Are you Pregnant _____ Are you Nursing? _____