PATIENT INFORMATION

CONFIDENTIAL

DATE _____

BIRTHDATE _____

(PLEASE PRINT)

NAME _____ (FIRST / MI / LAST) HOME PHONE _____ CELL PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

E-MAIL _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT'S OR PARENT'S EMPLOYER _____ WORK PHONE _____

SPOUSE OR PARENT'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _____ CITY _____ STATE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ FINANCIAL INSTITUTION _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ YES ☐ NO

REGARDING INSURANCE

I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ESTIMATED FEE FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR ON BEHALF OF MY DEPENDENTS, WITHIN 30 DAYS OF STATEMENT.

SIGNATURE

X _____

SIGNATURE OF PATIENT OR PARENT IF MINOR

PATIENT NAME _____ DATE OF BIRTH _____

HOME ADDRESS _____ HOME PHONE _____

_____ CELL PHONE _____

E-MAIL _____ SOC. SEC. NO. _____

PATIENT NAME

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU RECENTLY BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐	☐
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐
IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____		
4. DO YOU TAKE ANTIBIOTICS PRIOR TO DENTAL CARE?	☐	☐
5. DO YOU USE TOBACCO?	☐	☐

6. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	LOCAL ANESTHETICS (E.G. NOVOCAINE)	☐	☐	BARBITURATES	☐	☐	ASPIRIN
☐	☐	PENICILLIN OR OTHER ANTIBIOTICS	☐	☐	SEDATIVES	☐	☐	OTHER _____
☐	☐	SULFA DRUGS	☐	☐	CODEINE			_____

7. WOMEN ONLY:

	YES	NO
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
B) ARE YOU NURSING?	☐	☐
C) ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

8. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	AIDS OR HIV INFECTION	☐	☐	FAINTING / SEIZURES	☐	☐	LIVER DISEASE
☐	☐	ANEMIA	☐	☐	FIBROMYALGIA	☐	☐	LOW BLOOD PRESSURE
☐	☐	ANTICOAG THERAPY	☐	☐	GLAUCOMA	☐	☐	MIGRAINES
☐	☐	ASTHMA	☐	☐	HEART ATTACK	☐	☐	RHEUMATIC FEVER
☐	☐	CANCER	☐	☐	HEART DISEASE	☐	☐	SEASONAL / ALLERGIES
☐	☐	CARDIAC PACEMAKER	☐	☐	HEART MURMUR/MVP	☐	☐	STOMACH PROBLEMS
☐	☐	CARDIAC STENT THERAPY	☐	☐	HEART TROUBLE	☐	☐	STROKE
☐	☐	CHEMO/RADIATION THERAPY	☐	☐	HEPATITIS / JAUNDICE	☐	☐	THYROID PROBLEM
☐	☐	CHEST PAINS	☐	☐	HIGH BLOOD PRESSURE	☐	☐	TUBERCULOSIS
☐	☐	DIABETES	☐	☐	JOINT REPLACEMENT OR IMPLANT	☐	☐	OTHER _____
☐	☐	EMPHYSEMA	☐	☐	KIDNEY DISEASES	☐	☐	_____
☐	☐	EPILEPSY / CONVULSIONS	☐	☐	LEUKEMIA			

PATIENT COMMENTS

SIGNATURE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

X _____ _____

PATIENT, PARENT OR GUARDIAN DATE