PATIENT INFORMATION

CONFIDENTIAL

PATIENT # _____

(PLEASE PRINT)

DATE _____

NAME _____ (FIRST MI LAST) BIRTHDATE _____ HOME PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

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

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

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

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

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

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

RESPONSIBLE PARTY

Cell Phone # _____

Email address _____

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

ADDRESS _____ HOME PHONE _____

SOCIAL SECURITY NUMBER _____

EMPLOYER _____ WORK PHONE _____

ADDRESS _____

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

INSURANCE INFORMATION

Ins. ID# _____

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 INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

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? _____

X _____

SIGNATURE OF PATIENT OR PARENT IF MINOR

Health Information—Medical

Physician's Name

Address / Phone #

Are you presently under the care of a physician? If yes, please explain.

Have you ever had a serious illness or accident? If yes, please explain.

(Women) Are you pregnant? If yes, how long?

Are you allergic to:

Penicillin	yes	no	Local Anesthetic	yes	no
Codeine	yes	no	Other	yes	no

List all medications or drugs (and dosages) that you are taking.

Do any of the following apply to you now or in the past?

Heart disease	yes	no	Thyroid problem	yes	no	Tuberculosis, Lung disease	yes	no	Tumors	yes	no
Rheumatic fever	yes	no	Jaundice	yes	no	Asthma, Hay fever	yes	no	Glaucoma	yes	no
Heart murmur	yes	no	Hepatitis	yes	no	Sinus problems	yes	no	Radiation therapy	yes	no
Congenital heart defect	yes	no	Ulcers	yes	no	Epilepsy, Convulsions	yes	no	Prosthetic implant	yes	no
Abnormal blood pressure	yes	no	Diabetes	yes	no	Fainting spells	yes	no	Venereal disease	yes	no
Stroke	yes	no	Excessive thirst, urination	yes	no	Chemical dependency	yes	no	Arthritis	yes	no
Abnormal bleeding	yes	no	Anemia	yes	no	Mental health care	yes	no	HIV/Aids Related Complex	yes	no

The above information is correct to the best of my knowledge. I authorize the administration of such medications and performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care.

In the unlikely event that we must involve a collection agency for any outstanding balances, the patient/guarantor will be responsible for all fees associated with the collection agency.

Patient Signature _____ Date _____

D.D.S. Signature _____ Date _____

Updates (Staff use)

Have there been any changes in this patient's medical history, dental history or address and phone number?

☐ No Change Signed:	☐ Refer Progress Notes Date:	☐ No Change Signed:	☐ Refer Progress Notes Date:
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