Patient Information

Patient Name: _____ _____ ____ _____ Date: _____
Last First MI (Preferred Name)

Gender: ☐ Male ☐ Female Check One: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Child

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: ____ (Cell): _____

Email Address: _____ Preference: ☐ Email ☐ Text ☐ Home # ☐ Cell #

Address: _____ _____
Street Apartment #

_____ _____ _____
City State Zip Code

Employer: _____ Occupation: _____

Health Information

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints or Heart Valve
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Tuberculosis
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Osteoporosis Treatment w/ Fosamax, Boniva, Actonel, Aredia, Phen-Fen
- ☐ Pacemaker
- ☐ Kidney Disease
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tobacco Usage
- ☐ Latex Allergy
- ☐ **Premed Required:** _____
- ☐ **Pregnancy** Due Date: _____
- ☐ **Drug Allergy List:** _____
- ☐ Other _____

Current Medications and Purpose: _____

_____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, explain: _____

Are you now under the care of a physician? ☐ Yes ☐ No For what? _____

Name of Physician: _____ Phone: _____

Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor.

_____ Date: _____
Signature of patient, parent, or guardian

Update: _____ Date: _____
Signature of patient, parent, or guardian

Update: _____ Date: _____
Signature of patient, parent, or guardian

Update: _____ Date: _____
Signature of patient, parent, or guardian

Dental Health Information

Why have you come to the dentist today? _____

Date of your last dental visit: _____ Previous dentist's name: _____

Do you like your smile? ☐ Yes ☐ No If not, what would you change?: _____

Person Responsible for Account

Name: _____ Relationship to Patient: _____
☐ Male ☐ Female

Social Security Number: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: ____ (Cell): _____

Address: _____ _____
Street Apartment #

_____ _____ _____
City State Zip Code

Dental Insurance Information

Primary
Name of Insured: _____ _____ _____ Relationship to Patient: _____
Last First MI
Insured's Birth Date: _____ SS#: _____ Group #: _____

Insured's Employer: _____ Dental Insurance Company: _____

Secondary
Name of Insured: _____ _____ _____ Relationship to Patient: _____
Last First MI
Insured's Birth Date: _____ SS#: _____ Group #: _____

Insured's Employer: _____ Dental Insurance Company: _____

If this office accepts my insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature: _____ Date: _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative
☐ Dental office ☐ Yellow pages ☐ School ☐ Work ☐ Internet Name: _____

Consent for Services

To the best of my knowledge, the information provided is true and correct. I understand that it will be held in the strictest confidence and only be used to improve communication between the doctor and myself. I also give permission for the doctor or his staff to use and photos he may take to be used for lecturing and education purposes.

Signature: _____ Date: _____ Relationship to Patient: _____