Patient Information

Patient Name: ____ Date: ____________________

Last, First, MI (Preferred Name) Gender: ______

Social Security #: ________________________ Birth Date: ______________ Marital Status: S M D W Child

Phone (Home): __________________ ____(Work): ___________________Ext: ________

(Cell) ____________________E-Mail: ________________________________

Best Place for confirmation calls: Home____ Work____ Cell_____ Text Message _____ Email______

Street Address: ____Apt#: ________________

City: ___________________________________ State: ______________ Zip Code: ________________

Health Information

Date of Last Dental Visit: ______________________Reason For This Visit: ____________________

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

- ☐AIDS
- ☐Allergies__________ __________________
- ☐Anemia
- ☐Arthritis
- ☐Artificial Joints Date___________
- ☐Asthma
- ☐Blood Disease
- ☐Cancer
- ☐Codeine Allergy
- ☐Diabetes
- ☐Dizziness
- ☐Epilepsy
- ☐Excessive Bleeding
- ☐Fainting
- ☐Glaucoma
- ☐Growths
- ☐Hay Fever
- ☐Head Injuries
- ☐Heart Disease
- ☐Heart Murmur
- ☐Hepatitis
- ☐High Blood Pressure
- ☐Jaundice
- ☐Kidney Disease
- ☐Liver Disease
- ☐Mental Disorders
- ☐Nervous Disorders
- ☐Pacemaker
- ☐Penicillin Allergy
- ☐Currently Pregnant Due Date:_________
- ☐Radiation Treatment
- ☐Respiratory Problems
- ☐Rheumatic Fever
- ☐Rheumatism
- ☐Sinus Problems
- ☐Smoker
- ☐Stomach Problems
- ☐Stroke
- ☐Tuberculosis
- ☐Tumors
- ☐Ulcers
- ☐Venereal Disease
- ☐Plavix/Coumadin
- ☐Bisphosphonates (ex. Fosamax, Boniva, Actonel)

OTHER:

- ☐________________
- ☐________________

- Have you ever had a history of drug or alcohol abuse ☐Yes ☐No

If yes, please explain: ____

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

If yes, please explain: ____

- Are you now under the care of a physician for a particular medical condition? ☐Yes ☐No

If yes, please explain: ____

- Name of Physician: ______________________________Phone:__________________

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

If yes, please explain: ____

- List any medications and doses you area currently taking: ______________________________

____

To the best of my knowledge, all of the preceding answers and information are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of Patient, Parent, or Guardian: __________________________ Date: ______________

Referral Information

Whom may we thank for referring you to our practice? ☐Another Patient, Friend ☐Another Patient, Relative ☐Dental Office ☐Yellow Pages ☐Internet ☐School ☐Insurance ☐Other________________________________

Name of person or office referring you to our practice: ____

Responsible Party or Parent/Guardian Information

The following is for: ☐ The Patient ☐The Patient's Spouse ☐ Parent/Guardian

Name:____ Relationship to patient______________________

☐Married ☐Single ☐Other____________________ ☐ Male ☐ Female

Social Security #:________________________________ Birth Date:_______________

Home Phone: _______________________Work:_______________________Ext:__________(Cell)________________________

Street Address: ____Apt #:____________________

City: ____State:_________________________Zip Code:_______________

Employment Information

The following is for: ☐The Patient ☐Parent/Guardian

Employer Name:____ Phone #_________________________________

Street Address: ____

City: ___________________________________State:__________Zip:______________

Insurance Information

Primary Ins.

Name of Policy Holder: ____

Policy Holder's DOB: _______ Member Id#:____________________________ Social Security # _________________________

Name of Insurance Company: ____

Insurance Company's Address:____

City: ____State:_____________________Zip Code:__________________

Employers Name:____

Patient's Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other___________________________