Patient Information

Patient Name: _____ Date: _____
Last First MI

☐ Male ☐ Female Marital Status _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____
Can you accept texts ☐ Y ☐ N

Best time/number to call: _____ email _____

Address: _____
Street Apartment #

_____
City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient (name) _____

☐ Dental Office (name) _____ ☐ Yellow Pages ☐ Other _____

Responsible Party Information

Name: _____
☐ Male ☐ Female Marital Status _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Patient Information

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

DOB: _____

Health Information

Date of Last Dental Visit_____ Why are you here today? _____

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

- ☐ AIDS/HIV
- ☐ Allergies _____
- ☐ **Aspirin Therapy**
- ☐ Anemia
- ☐ Arthritis
- ☐ **Artificial Joints**
- ☐ **Artificial Valves**
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ **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
- ☐ **Pregnancy**
  Due date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ **Rheumatic Fever**
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Keflex Allergy
- ☐ **Latex Allergy**
- ☐ **Osteoporosis Therapy**
- ☐ Chemotherapy
- ☐ Birth Control
- ☐ **Mitral Valve Prolapse**
- ☐ Alzheimer's Disease
- ☐ **Tobacco use**
  How much: _____
  How long: _____
- ☐ **Other** _____
- ☐ **No to all the above**

• List current medications: _____

_____

• Allergies to Medications, Novocaine, other: _____

• Have you ever had any complications following dental treatment? 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? Yes No
If yes, please explain: _____

• Name of Physician:_____ Phone:_____

• Do you have any health problems that need further clarification? Yes No
If yes, please 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 doctors at the next appointment without fail.

_____Date: _____
Signature of patient, parent or guardian