CONFIDENTIAL PATIENT INFORMATION

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PLEASE PRINT OR WRITE LEGIBLY

Date: _____

PERSONAL INFORMATION

Name: _____ S.S. _____

Address: _____
STREET *CITY* *STATE* *ZIP CODE*

Telephone: Home: _____ Business: _____ Cell: _____

Birth Date: _____ Sex: _____ Marital Status: _____ Spouse Name: _____

Occupation: _____ Referred by: _____

Employer (Important): _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relationship: _____ S.S.#_____

Address: _____
STREET *CITY* *STATE* *ZIP CODE*

Telephone: Home: _____ Business: _____ Cell: _____

Employer (Important): _____

DENTAL INSURANCE INFORMATION

Primary Insurance Co: _____
INSURANCE COMPANY NAME *INSURANCE COMPANY PHONE NUMBER*

_____
STREET *CITY* *STATE* *ZIP CODE*

Employee: _____ Relationship: _____ S. S. #: _____

Birth Date: _____ Policy Number: _____

Secondary Insurance Co: _____
INSURANCE COMPANY NAME *INSURANCE COMPANY PHONE NUMBER*

_____
STREET *CITY* *STATE* *ZIP CODE*

Employee: _____ Relationship: _____ S. S. #: _____

Birth Date: _____ Policy Number: _____

EMERGENCY CONTACT PERSON

_____
NAME *ADDRESS* *PHONE NUMBER*

HEALTH INFORMATION

Personal Physician: _____

NAME *ADDRESS* *PHONE NUMBER*

PLEASE CHECK YES OR NOT FOR EACH QUESTION

YES NO

☐ ☐ 1. Have you been hospitalized within the past 2 years? For what? _____

☐ ☐ 2. Are you currently being treated by a physician? For what? _____

☐ ☐ 3. Are you currently taking any medications or drugs? What? _____

_____ _____ _____ _____

_____ _____ _____ _____

☐ ☐ 4. Do you smoke or use any tobacco products? How long? _____

☐ ☐ 5. Are you allergic to any drugs? What? _____

☐ ☐ 6. Are you allergic to any metals? If so, what? _____

☐ ☐ 7. Have you ever had a skin rash or other reactions to metal jewelry? If so, to what? _____

☐ ☐ 8. Do you bleed excessively upon injury? _____

☐ ☐ 9. Are you pregnant? _____

☐ ☐ 10. When was your last dental visit? _____

CHECK ANY OF THE FOLLOWING CONDITIONS WHICH YOU HAVE HAD

☐ Arthritis
☐ Asthma/Respiration Problems
☐ Blood Transfusion
☐ Cancer
☐ Diabetes
☐ Drug/Alcohol Abuse
☐ Epilepsy
☐ Glaucoma
☐ Heart Problems
☐ Heart Murmur
☐ Hepatitis
☐ High or Low Blood Pressure
☐ HIV/AIDS
☐ Jaundice
☐ Joint Replacements
☐ Kidney Problems
☐ Nervous Breakdown / Psychiatric Treatment
☐ Radiation Therapy
☐ Rheumatic Fever
☐ Sexually Transmitted Diseases
☐ Stroke
☐ Tuberculosis
☐ Other Diseases (please list)

_____

AUTHORIZATION AND RELEASE

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 me health. I authorize the dentist to release any information including the diagnosis and the records of any treatment of examinations rendered to me or my child during the period of such Dental Care to third party payors and/of health practitioners. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services o my behalf or my dependents.

X _____

Signature of patient or parent if minor

PATIENT NAME: _____ START DATE: _____

UPDATED: _____ UPDATED: _____

UPDATED: _____ UPDATED: _____

UPDATED: _____ UPDATED: _____