Patient Information Form

PLEASE PRINT AND COMPLETE ALL ENTRIES

Patient Name	Date of Birth	Social Security No.	Marital Status	Today's Date
	__/__/__			__/__/__

Address	Home Phone	Cell Phone
	(____) ____-______	(____) ____-______

City,State,Zip	

Employer Name	Employer Address	Employer City, State, Zip	Work Phone
			(____) ____-______

Spouse's Name (Last, First, MI)	DOB	Social Security No.	Spouse's Work Phone
	__/__/__		(____) ____-______

Nearest friend not living with you	Address (Street/City/State/ZIP)	Home Phone
		(____) ____-______

Nearest relative not living with you	Address (Street/City/State/ZIP)	Home Phone
		(____) ____-______

Emergency Contact	Relationship	Phone
		(____) ____-______

E-mail Address:	Referred by:

Tell us how you would prefer to be contacted for your appointments? Please circle which you prefer: TEXT PHONE E-MAIL

Who is financially responsible for this bill ? How will the bill be paid today?

INSURANCE INFORMATION

Primary Insurance Name	Address (Street/City/State/ZIP)		Phone
			(____) ____-______
Name of Insured	**Relationship**	**I.D. No.**	**Group No.**

Secondary Insurance Name	Address (Street/City/State/ZIP)		Phone
			(____) ____-______
Name of Insured	**Relationship**	**I.D. No.**	**Group No.**

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HEALTH HISTORY

Are you in good health? _____Yes _____No   Date of last physical exam ____________________

Has there been any change in your health within the past year? _____Yes ____No

Are you under the care of a physician? _____ For what condition? ____________________

Name and address of your physician ____________________

List any serious illness, operation, or hospitalization in the past 5 years. ____________________

____

List all prescription and non-prescription medicine you are currently taking. ____________________

____

Check all of the following diseases or problems you have experienced:

_____ Cardiovascular disease
_____ Sinus trouble
_____ Thyroid problem
_____ Persistent swollen glands in neck
_____ Allergies
_____ Asthma or hay fever
_____ Diabetes
_____ AIDS or HIV infection
_____ Sexually transmitted disease
_____ Tuberculosis

_____ Cancer
_____ Radiation to the head or neck area
_____Fainting spells/seizures
_____ Hepatitis, Jaundice, Liver disease
______Abnormal Bleeding
_____ Required a blood transfusion
_____ Blood disorder such as anemia
_____ Epilepsy/other neurological diseases
_____ Persistent cough/cough that produces blood
_____ Respiratory problems/emphysema/bronchitis

_____ Damaged/artificial heart valves
_____ Heart murmur/rheumatic heart disease
_____ History of rheumatic fever
_____ Artificial Knee/ WHEN ________
_____ Artificial Hip/WHEN ________
_____Other Artificial Joints/WHEN ________
_____ Arthritis/Painful swollen joints
_____ High blood pressure
_____ Gastric bypass

Are you ALLERGIC to or have had a reaction to:

_____ Local anesthetics
_____ Sulfa Drug
_____ Aspirin
_____ Iodine
_____ Penicillin /Amoxicillin

_____Other Antibiotics/Please LIST:
____
_____ Barbiturates, sedatives, sleeping
_____ Codeine or other narcotics/Please LIST
____

_____ Latex
_____Nuts
_____ OTHER ____________

Have you had any serious trouble associated with previous dental treatments?____________________

____

Do you use tobacco products?____________________

Women Only

Are you pregnant? _____Yes _____No   Are you using prescribed birth control? _____Yes _____No

Signature ______________________________