Patient Information Form

TODAYS DATE:_____

NAME (Last, First, Middle):_____TITLE:_____

ADDRESS:_____
Street City State Zip Code

PREFERRED NAME:_____ SS NO:_____-___-_____ DOB: _____

HOME PHONE:_(___)_____ MARITAL: S /M /D / W SEX: M / F

WORK PHONE:_(___)_____ CELL:_(___)_____ EMAIL:_____

EMPLOYER_____

How would you prefer us to contact you to confirm your appointments?
Please circle one: Home Work Cell Text Email
Referred by: _____

Primary Dental Insurance Coverage

SUBSCRIBER NAME:_____ REALTION TO PATEINT:_____

ADDRESS:_____

SS NO: _____-___-_____ ID NO:_____ DOB:_____

EMPLOYER:_____

INSURANCE CO:_____ GROUP NO:_____

ADDRESS:_____

Secondary Dental Insurance Coverage

SUBSCRIBER NAME:_____ RELATION TO PATIENT:_____

ADDRESS:_____

SS NO:___-___-____ ID NO: _____ EMPLOYER:_____

DOB: _____ ADDRESS:_____

INSURANCE CO:_____ GROUP NO:_____

ADDRESS:_____

Responsible Party

NAME AND ADDRESS:_____
DRIVERS LISCENE NO:_____
SIGNATURE:_____

Confidential Medical-Dental History Form

NAME (Last, First, Middle):_____ DOB:_____

REASON FOR TODAY'S VISIT:_____

Are you interested in a whiter smile? _____Yes _____ No

Are you now or have you recently been under a physician's care? _____Yes _____No
Reason:_____

Have you ever been a patient in a hospital or had any serious illness? _____Yes _____No
Explain:_____

Check any of the following that you have had or suspected:

YES	NO		YES	NO		YES	NO	
___	___	Arthritis	___	___	Hepatitis or Jaundice	___	___	Prolonged Bleeding
___	___	Rheumatic Fever	___	___	Liver Disease	___	___	Fainting Tendency
___	___	Heart Trouble	___	___	Cancer or Tumor	___	___	Epilepsy
___	___	Heart Murmur	___	___	Tuberculosis	___	___	Thyroid Disease
___	___	High / Low Blood Pressure	___	___	Diabetes	___	___	Glaucoma
___	___	Chest Pain	___	___	Kidney / Bladder Problems	___	___	Radiation Treatment
___	___	Stroke	___	___	Anemia	___	___	Mental Disorders
___	___	Shortness of Breath	___	___	Lung Disease	___	___	HIV or AIDS
___	___	Asthma / Hay Fever	___	___	Prosthetic Joint Replacements	___	___	Venereal Disease
___	___	Sinus Trouble	___	___	Blood Disease	___	___	Blood Transfusion
___	___	Mitral Valve Prolapse	___	___	Artificial Valves	___	___	Jaw Problems TMJ/ TM

Check any of the following that you are taking or have taken:

YES	NO		YES	NO		YES	NO	
___	___	Cortisone Drugs	___	___	Anticoagulants	___	___	Tranquilizers
___	___	Steroids	___	___	Blood Thinners	___	___	Sedatives

Are you taking any other medication? ___YES ___ NO If yes, explain:_____

Are you allergic to or do you suffer ill effects from any of the following?

YES	NO		YES	NO		YES	NO	
___	___	Penicillin	___	___	Codeine	___	___	Dental Anesthesia
___	___	Aspirin	___	___	Household Bleach	___	___	Other:_____

IN CASE OF AN EMEGERNCEY CONTACT NAME:_____ NO:_____

Women Only:
Are you pregnant? ___Yes ___ No If yes: How many months?_____ Are you breast feeding?_____
Are you presently taking medicine of any kind routinely? (Birth control pills, shots or implant, hormone therapy,etc.)
Explain:_____

RESPONSIBLE PARTY FOR PATIENT:
Name and Address:_____
Signature:_____

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services
Initials rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.