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Patient Information

Patient Name: _____ _____ Date: _____
Last First MI (Preferred Name)
Gender (M/F): ____ Marital Status: _____ Birth Date: _____Social Security # _____

Driver's License # _____ E-Mail Address: _____

Address: _____
Street Apartment #
_____
City State Zip Code
Phone #'s: Home_____ Work_____ Cell_____

Referral Information

Name of person, office, or other source referring you to our practice: _____

Spouse or Responsible Party Information

Name: _____ _____
Last First MI (Preferred Name)
Gender (M/F): ____ Marital Status: _____ Birth Date: _____ Social Security # _____

Driver's License # _____ E-Mail Address: _____

Address: _____
Street Apartment #
_____
City State Zip Code
Phone #'s: Home_____ Work_____ Cell _____

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary
Name of Insured: _____
Last First MI
Insured's Birth Date: _____ Social Security# _____ 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 Group #: _____

Insurance Carrier Name and Telephone #: _____

Secondary
Name of Insured: _____
Last First MI
Insured's Birth Date: _____ Social Security# _____ 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 Group #:_____

Insurance Carrier Name and Telephone #: _____

Health History

Do you have or have you ever had:

Yes	No		Yes	No	
___	___	Artificial joint (knee, hip, other)	___	___	Tuberculosis
___	___	Bacterial endocarditis	___	___	Hepatitis or jaundice
___	___	Artificial heart valves	___	___	Prolonged bleeding
___	___	Rheumatic fever	___	___	Cancer (Type_____)
___	___	Mitral valve prolapse	___	___	Asthma or hayfever
___	___	Pacemaker	___	___	Kidney disease
___	___	Abnormal blood pressure	___	___	Thyroid disease
___	___	AIDS or HIV positive	___	___	Venereal disease
___	___	Fainting tendency	___	___	Chemical dependency
___	___	Psychiatric treatment	___	___	Diabetes
___	___	Epilepsy			

Any other condition:_____

_____

Describe any medical treatment (other than examinations) you have had in the past 12 months_____

_____

Are you allergic to:

Yes	No		Yes	No	
___	___	Penicillin	___	___	Codeine
___	___	Other medications (please list):_____			

_____

Are you currently taking:

Yes	No		Yes	No	
___	___	Cortisone/Steroids	___	___	Sedatives
___	___	Tranquilizers	___	___	Blood thinners
___	___	Birth control medication	___	___	Antibiotics
___	___	Other medications (please list):_____			

_____

Females:

Yes	No	
___	___	Are you pregnant? If yes, what is the delivery date?_____

Other:

Name of your physician:_____ Phone number:_____

Signature:

_____ _____

Your Name Date

Dental History

What is the purpose of your visit today?_____

Have you been treated by a: ___Periodontist ___Endodontist ___Oral Surgeon ___Orthodontist

Have you had nitrous oxide gas for dental treatment?_____

What is the date of your last dental visit? _____ What was done? _____