Patient Information Sheet

Patient Name _____ Male / Female
First Middle Last

Social Security # _____ Date of Birth _____ Age _____

Address _____ Home Phone _____

City/State/ZIP _____ Cell Phone _____

Patient Employer/School _____ Work Phone _____

Dentist _____ Physician _____

How did you hear about us? _____

Financial Information

Financially responsible party _____
First Middle Last

Relationship to patient (circle) Self Spouse Parent/Guardian Other _____

Social Security # _____ Date of Birth _____

Address _____ Home Phone _____

City/State/ZIP _____ Cell Phone _____

Employer _____ Work Phone _____

Insurance Information

Dental: Primary Insurance _____ Subscriber Name _____

Relationship to Patient _____ SSN _____ Date of Birth _____

Group # _____ Member ID # _____

Dental: Secondary Insurance _____ Subscriber Name _____

Relationship to Patient _____ SSN _____ Date of Birth _____

Group # _____ Member ID # _____

Medical: Primary Insurance _____ Subscriber Name _____

Relationship to Patient _____ SSN _____ Date of Birth _____

Group # _____ Member ID # _____

Medical: Secondary Insurance _____ Subscriber Name _____

Relationship to Patient _____ SSN _____ Date of Birth _____

Group # _____ Member ID # _____

I acknowledge that I am financially responsible for all charges. I hereby authorize the doctor to release information necessary to secure payment of benefits. In addition, I have read and signed the Financial Policy and Privacy Policy sheets.

Patient or responsible adult _____ Date _____

Please answer all questions by circling Yes or No. Please provide details below.

1. List serious illnesses, operations or hospitalizations. _____

_____

2. Any adverse effects to dental treatment? ..... Y N

3. Do you have or have you ever had any of the following? If so, please circle condition.

Rheumatic fever or rheumatic heart disease? ..... Y N
Congenital heart disease? ..... Y N
Cardiovascular disease (heart trouble, heart attack, heart murmur, heart surgery, chest pains, coronary artery disease, high blood pressure, stroke, pacemaker)? ..... Y N
Lung diseases (asthma, emphysema, TB)? ..... Y N
Seizures, epilepsy, psychiatric treatment, dizziness? ..... Y N
Fainting during medical treatment? ..... Y N
Bleeding disorder, anemia, bleeding tendency? ..... Y N
Liver disease (jaundice, hepatitis)? ..... Y N
Kidney disease, diabetes, thyroid disease? ..... Y N
Stomach ulcers, colitis, GI problems? ..... Y N
Implants placed anywhere in the body (heart valve, hip, knee)? ..... Y N
Radiation, x-ray treatments for therapy? ..... Y N
Clicking or popping of jaw joint, TMJ problems, clenching, grinding? ..... Y N
Sinus or nasal problems? ..... Y N
Autoimmune disease such as lupus or rheumatoid arthritis? ..... Y N
HIV, AIDS, depressed immune system? ..... Y N
Taken medications for osteoporosis (for your bones)? ..... Y N

4. Are you currently taking any medications, pills or drugs? If yes, please list. _____

_____

5. Are you allergic or have you had a bad reaction to any of the following? If so, please circle.

Local anesthetic (Novocaine, Lidocaine)? ..... Y N
Penicillin, Ampicillin or other antibiotics? ..... Y N
Barbiturates, sedatives, other anesthetics? ..... Y N
Aspirin, ibuprofen, other pain medications? ..... Y N
Latex or rubber products? ..... Y N
Other allergies? ..... Y N

6. Do you smoke, chew tobacco, use alcohol? How much daily? _____

7. Have you sought professional care for drug abuse, alcoholism or emotional problems? ..... Y N

8. Women: Are you pregnant or planning pregnancy? ..... Y N
Are you taking hormone replacement or birth control? ..... Y N

9. Do you wish to talk with the doctor privately about anything? ..... Y N

10. Do you have any other condition the doctor should know about? ..... Y N

Additional information: _____

_____

Patient or responsible adult _____ Date _____