PATIENT INFORMATION

CONFIDENTIAL

(PLEASE PRINT)

DATE _____

NAME _____ BIRTHDATE _____

HOME PHONE _____ CELL PHONE _____

IS THERE AN E-MAIL ADDRESS WHICH YOU WOULD LIKE US TO USE? _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

PATIENT'S OR PARENT'S EMPLOYER _____ WORK PHONE _____

SPOUSE OR PARENT'S NAME _____ EMPLOYER _____ WORK PHONE _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

(IN THE CASE OF CHILDREN OF DIVORCED PARENTS, WE CONSIDER THE PARENT WHO BRINGS THE CHILD TO OUR OFFICE TO BE THE RESPONSIBLE PARTY.)

ADDRESS (IF DIFFERENT) _____ HOME PHONE _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

DENTAL INSURANCE INFORMATION

FOR OUR PATIENTS WITH DENTAL INSURANCE, WE EXPECT PAYMENT OF COPAYS AND DEDUCTIBLES ON THE DAY OF SERVICE.

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____

NAME OF EMPLOYER _____ WORK PHONE _____

INSURANCE COMPANY NAME _____ PHONE # _____ GROUP # _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL/COLLEGE _____ CITY _____ STATE ____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____

NAME OF EMPLOYER _____ WORK PHONE _____

INSURANCE COMPANY NAME _____ PHONE # _____ GROUP # _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐	☐
3. PLEASE LIST ALL MEDICATION(S) THAT YOU TAKE, INCLUDING NON-PRESCRIPTION _____		
4. DO YOU USE TOBACCO?	☐	☐
5. DO YOU HAVE A HISTORY OF DRUG/ALCOHOL ABUSE?	☐	☐
6. ARE YOU WEARING CONTACT LENSES?	☐	☐

	YES	NO
7. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO ANY DRUGS? IF YES, PLEASE SPECIFY _____	☐	☐
8. WHEN WAS YOUR LAST COMPLETE PHYSICAL? _____		
9. WOMEN ONLY:		
A. ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
B. ARE YOU NURSING?	☐	☐
C. ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

10. PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.

☐HIGH BLOOD PRESSURE	☐HEART DISEASE	☐HEART ATTACK	☐CARDIAC PACEMAKER
☐EASILY WINDED	☐AIDS OR HIV INFECTION	☐RHEUMATIC FEVER	☐HEART MURMUR
☐STROKE	☐ SWOLLEN ANKLES	☐ANGINA	☐STOMACH TROUBLE/ULCERS
☐HAY FEVER/ALLERGIES	☐HEPATITIS/JAUNDICE	☐FAINTING/SEIZURES	☐TUBERCULOSIS
☐ANEMIA	☐ASTHMA	☐ CANCER	☐SEXUALLY TRANSMITTED DISEASE
☐RADIATION THERAPY	☐ GLAUCOMA	☐EMPHYSEMA	☐ JOINT REPLACEMENT OR IMPLANT
☐ ARTHRITIS	☐RESPIRATORY PROBLEMS	☐EPILEPSY/CONVULSIONS	☐HEART TROUBLE
☐LEUKEMIA	☐ LIVER DISEASE	☐DIABETES	☐OTHER _____

COMMENTS _____

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 MY HEALTH. I HAVE RECEIVED A COPY OF THIS PRACTICE'S PRIVACY NOTICE. I UNDERSTAND THAT THIS PRACTICE RESERVES THE RIGHT TO CHARGE MY ACCOUNT FOR A CANCELLATION WITH LESS THAN 24 HOURS NOTICE.

X _____ _____

SIGNATURE OF PATIENT OR PARENT IF MINOR DATE