Patient Information

Patient Name: _____ Date: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Cell): _____ Email: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Currently Pregnant Due date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

- ☐ _____ _____ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Please list all medications you are currently taking.

_____

_____

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent, or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Friend ☐Relative ☐Google ☐Insurance

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

Spouse or Responsible Party Information

The following is for: ☐ the patient's parent ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female Social Security #: _____

Birth Date: _____

Phone (Home): _____ (Cell): _____

Address: _____
Street Apartment #

_____
City State Zip Code

Insurance Information

Primary

Name of Insured: _____

Insured's Birth Date: _____ ID #: _____

Group #: _____Insured's Zip Code if Metlife:_____

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Carrier Name: _____

Insurance Address: _____

Insurance Phone Number: _____

Secondary

Name of Insured: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Birth Date: _____ ID #: _____

Group #: _____Insured's Zip Code if Metlife: _____

Insured's Employer Name: _____

Insurance Carrier Name: _____

Insurance Address: _____

Insurance Phone Number: _____

Signature_____Date_____