Patient Information Form

PATIENT

Name _____ _____
Last First

Address _____ Apt. # ____

City _____ ZIP _____

How long at this address? _____

Phone _____ Cell _____

Email _____

Social Security # _____

Driver's License # _____

Age _____ Date of birth _____

RESPONSIBLE PARTY (Skip if same as above)

Name _____ _____
Last First

Address _____ Apt. # ____

City _____ ZIP _____

How long at this address? _____

Relationship to patient _____

SSN # _____ Driver's Lic. # _____

Age _____ Date of birth _____

EMPLOYMENT

Occupation _____

Employer _____

Length of employment _____

Business address _____

City _____ ZIP _____

Business phone _____ Ext. _____

EMERGENCY CONTACT

Name _____ Phone _____

HOW DID YOU HEAR ABOUT US?

- ☐ Family/friends
- ☐ Newspaper
- ☐ Radio
- ☐ Office sign
- ☐ Office transfer
- ☐ Yellow Pages
- ☐ Billboard
- ☐ Our website
- ☐ Direct mail
- ☐ Flyer/coupon
- ☐ Online search
- ☐ Online ad
- ☐ Insurance plan
- ☐ TV

Do you have family or friends who may need dental care?
If so, please list name(s) and relationship(s):

Were you referred by anyone? _____

INSURANCE / DENTAL PLAN (primary)

Plan Name _____

Address _____

City _____ ZIP _____

Insurance/Plan Phone # _____

Insured's name _____

Union _____ Group # _____ Plan # _____

Insured's SSN # _____ Date of birth _____

INSURANCE / DENTAL PLAN (secondary)

Plan Name _____

Address _____

City _____ ZIP _____

Insurance/Plan Phone # _____

Insured's name _____

Union _____ Group # _____ Plan # _____

Insured's SSN # _____ Date of birth _____

1. I certify that the information provided is accurate and will be used to grant credit and provide dental services. I understand that I am financially responsible for all charges not covered by or paid by my insurance for any reason.
2. By signing below, I authorize that you may verify and exchange information on me and any additional applicants, including reports from credit reporting agencies.
3. I authorize payment directly to the dentist of any group insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges not covered by this authorization. I authorize release of any information relating to any dental claim(s).
4. I understand that this dental practice is owned and operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist or corporate entity is responsible for my dental treatment.

_____ _____
Signature of Patient or Responsible Party (Parent if patient is a minor) Date

(Please complete both sides)

Dental History

Date _____

Patient name _____ (Last) _____ (First) Date of birth _____ Age _____

Reason for visit _____ Other _____

Do you have any health conditions we should be aware of? ☐ Yes ☐ No _____

Date of last visit to a dentist _____ Treatment performed _____

Was the treatment completed? _____ When were dental x-rays taken? _____

Did you have a cleaning? ☐ Yes ☐ No Have you had periodontal (gum) treatment? ☐ Yes ☐ No

Please check if any of the following apply to you:

☐ Problems with past dental treatment ☐ Bleeding after an extraction ☐ Teeth grinding ☐ Jaw clinching

☐ Ear problems (including popping, locking, pain and clicking) ☐ Temporomandibular Joint Dysfunction (TMJ) Description _____

MEDICAL INFORMATION

Are you under a doctor's care? ☐ Yes ☐ No If yes, please specify _____ Dr. name _____ Phone _____

Are you allergic to penicillin, local anesthetics, tranquilizers, codeine or any other medicine? _____

Are you currently taking any medications (inc. birth control? (If yes, specify) _____

Are you pregnant? If so, how many months? _____

Do you have other health problems we should be aware of? _____

Please check if you've had any of the following:

☐ Artificial heart valve	☐ Chemo/rad therapy	☐ Heart surgery	☐ Liver problems	☐ Sleep apnea
☐ AIDS/HIV	☐ Cosmetic surgery	☐ Heart problems	☐ Low blood pressure	☐ Smoking tobacco
☐ Anemia	☐ Diabetes	☐ Hepatitis	☐ Lung disease	☐ Stroke
☐ Angina	☐ Dizziness or fainting	☐ High blood pressure	☐ Pacemaker	☐ Thyroid problems
☐ Arthritis	☐ Drug addiction	☐ Jaundice	☐ Phen-fen	☐ TMD or TMJ
☐ Asthma	☐ Epilepsy	☐ Joint replacement	☐ Psychiatric care	☐ Tuberculosis
☐ Bleeding problems	☐ Glaucoma	☐ Kidney disease	☐ Rheumatic fever	☐ Venereal disease
☐ Cancer	☐ Heart attack	☐ Latex allergy	☐ Sinus trouble	

Doctor comments _____

I have answered every question completely and accurately to the best of my knowledge. I will inform my dentist of hanges in my health and/or medication. I certify that I consent to taking x-rays and an oral examination.

Signature of Patient or Responsible Party (Parent if patient is a minor) _____ Date _____ Signature of doctor _____

MEDICAL UPDATE:

Patient signature _____ Doctor signature _____ Date _____

Patient signature _____ Doctor signature _____ Date _____