

NEW PATIENT INFORMATION FORM

LAST NAME: \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE: \_\_\_\_\_

NICKNAME: \_\_\_\_\_ SS#: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ MARITAL STATUS: \_\_\_\_\_ SEX: \_\_\_\_\_

EMPLOYER NAME AND ADDRESS: \_\_\_\_\_

REFERRING DR: \_\_\_\_\_ REFERRING PT: \_\_\_\_\_

PRIMARY INSURANCE COVERAGE

SUBSCRIBER NAME AND ADDRESS: \_\_\_\_\_

RELATION TO PATIENT: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

EMPLOYER NAME AND ADDRESS: \_\_\_\_\_

INSURANCE COMPANY NAME AND ADDRESS: \_\_\_\_\_

GROUP #: \_\_\_\_\_ FAMILY YRLY DEDUCT: \_\_\_\_\_ INDIV YRLY DEDUCT: \_\_\_\_\_

SECONDARY INSURANCE COVERAGE

SUBSCRIBER NAME AND ADDRESS: \_\_\_\_\_

RELATION TO PATIENT: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

EMPLOYER NAME AND ADDRESS: \_\_\_\_\_

INSURANCE COMPANY NAME AND ADDRESS: \_\_\_\_\_

GROUP #: \_\_\_\_\_ FAMILY YRLY DEDUCT: \_\_\_\_\_ INDIV YRLY DEDUCT: \_\_\_\_\_

RESPONSIBLE PARTY FOR PATIENT:

Name and Address: \_\_\_\_\_

Signature: \_\_\_\_\_

Please write any additional insurance information on the back of this form - Thank You!

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, \_\_\_\_\_ have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
Signature Date

(You May Refuse to Sign This Acknowledgement)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other \_\_\_\_\_

# PATIENT MEDICAL INFORMATION

PATIENT NAME : \_\_\_\_\_ DATE : \_\_\_\_\_

PREFERRED NAME (NICKNAME): \_\_\_\_\_ DATE OF BIRTH : \_\_\_\_\_

SEX : M F

IS YOUR GENERAL HEALTH GOOD? ..... YES \_\_\_ NO \_\_\_  
 DO YOU SMOKE OR USE TOBACCO? ..... YES \_\_\_ NO \_\_\_  
 ARE YOU USING BIRTH CONTROL PILLS/IMPLANT? YES \_\_\_ NO \_\_\_  
 ARE YOU PREGNANT?..... YES \_\_\_ NO \_\_\_

| Y N Conditions  | Y N Conditions  | Y N Conditions   |
|---|---|--|
| <input type="checkbox"/> <input type="checkbox"/> Abnormal Bleeding       | <input type="checkbox"/> <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> <input type="checkbox"/> Alcohol Abuse           | <input type="checkbox"/> <input type="checkbox"/> Hay Fever             | <input type="checkbox"/> <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> <input type="checkbox"/> Allergies               | <input type="checkbox"/> <input type="checkbox"/> Heart Attack          | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> <input type="checkbox"/> Anemia                  | <input type="checkbox"/> <input type="checkbox"/> Heart Surgery         | <input type="checkbox"/> <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> <input type="checkbox"/> Angina Pectoris         | <input type="checkbox"/> <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis               | <input type="checkbox"/> <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> <input type="checkbox"/> Yellow Jaundice  |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Bones        | <input type="checkbox"/> <input type="checkbox"/> Hepatitis B           |  |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve  | <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure   |  |
| <input type="checkbox"/> <input type="checkbox"/> Asthma                  | <input type="checkbox"/> <input type="checkbox"/> HIV+ AIDS             |  |
| <input type="checkbox"/> <input type="checkbox"/> Blood Transfusion       | <input type="checkbox"/> <input type="checkbox"/> Kidney Problems       |  |
| <input type="checkbox"/> <input type="checkbox"/> Cancer- Chemotherapy    | <input type="checkbox"/> <input type="checkbox"/> Liver Disease         |  |
| <input type="checkbox"/> <input type="checkbox"/> Colitis                 | <input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure    |  |
| <input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse |  |
| <input type="checkbox"/> <input type="checkbox"/> Cosmetic Surgery        | <input type="checkbox"/> <input type="checkbox"/> Pace Maker            |  |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes                | <input type="checkbox"/> <input type="checkbox"/> Pneumocystitis        |  |
| <input type="checkbox"/> <input type="checkbox"/> Difficulty Breathing    | <input type="checkbox"/> <input type="checkbox"/> Psychiatric Problems  |  |
| <input type="checkbox"/> <input type="checkbox"/> Drug Abuse              | <input type="checkbox"/> <input type="checkbox"/> Radiation Therapy     |  |
| <input type="checkbox"/> <input type="checkbox"/> Emphysema               | <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever       |  |
| <input type="checkbox"/> <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> <input type="checkbox"/> Seizures              |  |
| <input type="checkbox"/> <input type="checkbox"/> Fainting Spells         | <input type="checkbox"/> <input type="checkbox"/> Shingles              |  |
| <input type="checkbox"/> <input type="checkbox"/> Fever Blisters          | <input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease   |  |
| <input type="checkbox"/> <input type="checkbox"/> Frequent Headaches      | <input type="checkbox"/> <input type="checkbox"/> Sinus Problems        |  |

Y N Allergies

Aspirin

Codeine

Dental Anesthetics

Erythromycin

Jewelry

Latex

Metals

Penicillin

Tetracycline

Other \_\_\_\_\_

| MEDICATIONS YOU ARE TAKING | REASON |
|----------------------------|--------|
|                            |        |
|                            |        |
|                            |        |
|                            |        |
|                            |        |

APPROXIMATE TIME SINCE LAST DENTAL EXAM? \_\_\_\_\_

PHYSICIAN : \_\_\_\_\_

Person filling out Medical History \_\_\_\_\_

REFERRED BY: NAME \_\_\_\_\_

THANK YOU !

YELLOW PAGES \_\_\_\_\_  
 SIGN OUT FRONT \_\_\_\_\_

Gary W. Stewart, D.D.S.  
 Jacob D. Young, D.D.S.  
 Family Dentistry