COMPLETE PREVENTIVE DENTISTRY, INC.

Patient's First Name ____________________ Last Name ____________________

Street ____________________ City ____________ State ________ Zip ______

Home Ph ( ) _____ - _______ Work Ph ( ) _____ - _______ Cell Ph ( ) _____ - _______ Can we text you? ❏ Yes ❏ No

SS# ____________________ DOB __________ Sex ________ Marital Status __________

Driver's License # ____________________ Email Address ____________________

Referred by ______________ Reason for visit ____________________

How did you hear about us? ____________________

Responsible Party First Name ____________________ Last Name ____________________

Responsible Party Address ____________________ City ____________________

State ____________________ Zip ____________________

SS# ______________ DOB __________ Sex ______ Relationship to Patient __________

Driver's License # ____________________ Email Address ____________________

Employer ____________________ Address ____________________

Home Ph ( ) _____ - _______ Work Ph ( ) _____ - _______ Cell Ph ( ) _____ - _______

INSURANCE

Primary Insurance Company

Name of Insured ____________________ Insured's Birthdate __________ Insured's SS# __________

Relationship to Patient ____________________ Employer ______________ Group # __________

Employer's Address ____________________ City ____________ State ________ Zip ______

Secondary Insurance Company

Name of Insured ____________________ Insured's Birthdate __________ Insured's SS# __________

Relationship to Patient ____________________ Employer ______________ Group # __________

Employer's Address ____________________ City ____________ State ________ Zip ______

HEALTH HISTORY

Physician ____________________ Address ____________________ Phone __________

Last Physical ____ / ____ / ____ Current Medications? ____________________

Please check all which you have had or presently have:

❏ Heart Disease ______________
❏ Stroke ______________
❏ Rheumatic Fever ______________
❏ Heart Murmur ______________
❏ Ulcers ______________
❏ Blood Disease ______________
❏ Anemia ______________
❏ Sinus Trouble ______________
❏ Emphysema ______________
❏ Tuberculosis ______________
❏ Respiratory Problem ______________
❏ Asthma ______________
❏ HIV+ ______________
❏ Currently Pregnant ______________
❏ Glaucoma ______________
❏ Artificial Joint ______________
❏ Jaundice/Hepatitis ______________
❏ Fainting Spells ______________
❏ High/Low Blood Pressure ______________
❏ Arthritis ______________
❏ Diabetes ______________
❏ Epilepsy or Seizures ______________
❏ Thyroid Problem ______________
❏ Blood Transfusion ______________
❏ Allergy to Medicine ______________
❏ Allergy to Penicillin ______________
❏ Allergy to Anesthetics ______________
❏ Allergy to Latex ______________
❏ Cancer ______________
❏ Drug Dependency ______________

Have you ever been treated with radiation? ❏ Yes ❏ No

Other Health Problems? ____________________

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT, UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

Signature ____________________ Date __________

HEALTH HISTORY UPDATE

Date: ______________________ Completed by: ______________________

Current Medications: Health Changes/Notes:

Date: ______________________ Completed by: ______________________

Current Medications: Health Changes/Notes:

Date: ______________________ Completed by: ______________________

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Date: ______________________ Completed by: ______________________

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