CONFIDENTIAL PATIENT INFORMATION

Soc. Sec. # ____________

Date ____________

PATIENT INFORMATION

Name ____________ Birthdate ____________ Home Phone ____________

Address ____________ Apt # ______ City ____________ State ______ ZIP ______

Check Appropriate Box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

If Student, Name of School/College ____________ City ____________ State ______ ❑ Full Time ❑ Part Time

Patient's or Parent's Employer ____________ Work Phone ____________

Business Phone ____________ City ____________ State ______ ZIP ______

Spouse's Name ____________ Employer ____________ Work Phone ____________

Whom May We Thank for Referring You? ____________

RESPONSIBLE PARTY

Name of Financially Responsible Person ____________ Relationship to Patient ____________

Address ____________ Home Phone ____________

Birthdate ____________ SSN # ____________ Employer ____________ Work Phone ____________

Is this Person Currently a Patient in our Office? ❑ Yes ❑ No

DENTAL INSURANCE INFORMATION **(Must Be Complete)**

Name of Insured ____________ Relationship to Patient ____________

Birthdate ____________ SSN # ____________

Name of Employer ____________ Union or Local # ____________ Work Phone ____________

Insurance Company ____________ Group # ____________ Policy/ID # ____________

Ins. Co. Address ____________ City ____________ State ______ ZIP ______

Insurance Company Phone Number ____________

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all cost of dental treatment. I hereby authorize the Dental Office to administer treatment and perform diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental and medical history are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical history and other information about my dental treatment to third party payors and or health professionals.

Patient Signature (Parent or Guardian) ____________ Date ____________

Medical History

Patient Name____

		Please Circle	
Are you under a physician's care now?________________Why?__________________________Phone#_______________		Yes	No
Have you ever been hospitalized or had a major operation? Discuss______________________________________		Yes	No
Have you every had a serious injury to your head or neck? Discuss______________________________________		Yes	No
Are you taking any medications, pills or drugs? What?____		Yes	No
Are you on a special diet? Discuss____		Yes	No

Are you allergic to any medications or substances? Please check box below Yes No

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other_______________

WOMEN (Please check) ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss__________ Yes No

Person to contact in case of emergency__________________________________Phone_______________________

Do you now have or have you ever had any of the following? Please check appropriate boxes.

*If yes to any of the starred conditions, please call prior to your appointment . . . premedication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	☐	☐	Anemia	☐	☐	Ulcers	☐	☐	Pain in Jaw Joints	☐	☐
Heart Murmur*	☐	☐	Excessive Bleeding	☐	☐	Recent Weight Loss	☐	☐	Cortisone Medicine	☐	☐
Irregular Heart Beat	☐	☐	Sickle Cell Disease	☐	☐	Frequent Diarrhea	☐	☐	Artificial Joint*	☐	☐
Angina/Chest Pain	☐	☐	Hemophelia (Bleeding Problem)	☐	☐	Diabetes	☐	☐	Venereal Diseae	☐	☐
Heart Attack/Failure	☐	☐	Lung Disease	☐	☐	Excessive Thirst	☐	☐	AIDS	☐	☐
Congenital Heart Disorder	☐	☐	Breathing Problem	☐	☐	Hypoglycemia	☐	☐	Allergies (Medicines)	☐	☐
Mitral Valve Prolapse*	☐	☐	Sinus Trouble	☐	☐	HIV Positive	☐	☐	Hives or Rash	☐	☐
Scarlet Fever	☐	☐	Asthma	☐	☐	Genital Herpes	☐	☐	Fever Blisters	☐	☐
Rheumatic Fever*	☐	☐	Liver Disease	☐	☐	Drug Addiction	☐	☐	Stroke	☐	☐
Artificial Heart Valve*	☐	☐	Hepatitis A (Infectious)	☐	☐	Yellow Jaundice	☐	☐	Epilepsy or Seizures	☐	☐
Heart Pace Maker	☐	☐	Hepatitis B or C	☐	☐	Kidney Problems	☐	☐	Fainting or Dizziness	☐	☐
Heart Surgery*	☐	☐	Emphysema	☐	☐	Renal Dialysis	☐	☐	Tumors or Growths	☐	☐
High Blood Pressure	☐	☐	Tuberculosis	☐	☐	Thyroid Disease	☐	☐	Psychiatric Care	☐	☐
Low Blood Pressure	☐	☐	Cancer	☐	☐	Parathyroid Disease	☐	☐	Alzheimer's Disease	☐	☐
Blood Disease	☐	☐	X-Ray Treatments (Radiation)	☐	☐	Arthritis/Gout	☐	☐	Glaucoma	☐	☐
Bruise Easily	☐	☐	Chemotherapy	☐	☐	Rheumatism	☐	☐			

Have you ever had any other serious illness not checked above? Discuss______________________________ Yes No

Do you wish to talk to the dentist privately about any problem?__________________________________ Yes No

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I will inform the dentist and staff at the next appointment without fail.

X____Date______________________

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor____Date________________BP__________

History Review and Significant Findings: ____

____

____

I have read my MEDICAL HISTORY dated__________________and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	REVIEWED BY
__________	____________________	None ☐	____________________	________	Dr.__________
__________	____________________	None ☐	____________________	________	Dr.__________
__________	____________________	None ☐	____________________	________	Dr.__________
__________	____________________	None ☐	____________________	________	Dr.__________
__________	____________________	None ☐	____________________	________	Dr.__________
__________	____________________	None ☐	____________________	________	Dr.__________
__________	____________________	None ☐	____________________	________	Dr.__________
__________	____________________	None ☐	____________________	________	Dr.__________