

PATIENT INFORMATION

First Name _____ M.I. _____ Last Name _____ Sex Male Female
 Date of Birth _____ Age _____ Social Security # _____
 Home Tel. # (____) _____ Business Tel. # (____) _____ Cell # (____) _____
 Address _____ Apt. # _____ City _____ State _____ Zip _____
 Mailing Address _____ City _____ State _____ Zip _____
 Employer _____ Tel. # (____) _____
 Dentist _____ Physician _____ Referred By _____

If other than above, who will be responsible for your account? Spouse Mom Dad Other _____
 Name _____ Social Security # _____ Tel. # (____) _____
 Address _____ City _____ State _____ Zip _____
 Employer _____ Tel. # (____) _____

PRIMARY INSURANCE INFORMATION

Policy Holder Name _____
 Patient Relationship to Policy Holder:
 Self Spouse Child Other
 Sex of Policy Holder Male Female Date of Birth: _____
 Policy Holder Address _____
 City _____ State _____ Zip _____
 Employer _____
 Tel. # _____ SS # _____

SECONDARY INSURANCE INFORMATION

Policy Holder Name _____
 Patient Relationship to Policy Holder:
 Self Spouse Child Other
 Sex of Policy Holder Male Female Date of Birth: _____
 Policy Holder Address _____
 City _____ State _____ Zip _____
 Employer _____
 Tel. # _____ SS # _____

PRIMARY DENTAL INSURANCE COMPANY:

Name of Ins. Co. _____
 Address _____
 Tel. # (____) _____
 Does your plan cover: Dental Medical Both
 Group # _____ Group Name _____
 Local _____

SECONDARY DENTAL INSURANCE COMPANY:

Name of Ins. Co. _____
 Address _____
 Tel. # (____) _____
 Does your plan cover: Dental Medical Both
 Group # _____ Group Name _____
 Local _____

PRIMARY MEDICAL INSURANCE COMPANY:

Name of Ins. Co. _____
 Address _____
 Tel. # (____) _____
 Does your plan cover: Dental Medical Both
 Group # _____ Group Name _____
 Local _____

SECONDARY MEDICAL INSURANCE COMPANY:

Name of Ins. Co. _____
 Address _____
 Tel. # (____) _____
 Does your plan cover: Dental Medical Both
 Group # _____ Group Name _____
 Local _____

Payments are due within 30 days of service. In cases where insurance claims are pending, monthly payments on your account are expected. A finance charge of 1-1/2% month (annual percentage rate of 18%) will appear on ALL charges outstanding for more than 90 days. The patient agrees to pay any collection fees, costs and reasonable attorney fees in the event is instituted. We are not providers with DSHS we do not accept Medical Coupons.

Guarantors Signature _____

Date _____

MEDICATION

Please list any pills, drugs, or medications you have taken in the past year and what you are taking them for

Name	Dosage	Condition Being Treated
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

ALLERGIES

Please list any medicines you are allergic to; describe the type of reaction

Name	Reaction
1.	
2.	
3.	
4.	
5.	
6.	

WOMEN

Yes ___ No ___ Is there a possibility of you being pregnant?

Yes ___ No ___ Are you currently breast feeding?

Yes ___ No ___ Are you taking birth control pills? *(Note: Prolonged use of Antibiotics (longer than two weeks) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.)

I certify that I have read and understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon or any other member of his staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: _____ Date _____

Health History Update

Date	Changes	Initials