# PATIENT INFORMATION

| Last Name: | First Name: | Middle Initial: | [ ] Male [ ] Female |
|---|---|---|---|
| Address: | City: | | Zip: |
| Social Security Number: | | Birth Date: | |
| Home Phone: | Cell Phone: | Work Phone: | |
| Physician's Name: | | Phone: | |
| Previous Dentist's Name: | | Phone: | |
| Emergency Contact Person: | | Phone: | |
| Person to Contact for Appointments: | | Relation to Patient: | |

## INSURANCE INFORMATION/RESPONSIBLE PARTY

| Name of Insured: | Relation to Patient: |
|---|---|
| Social Security Number: | Birth Date: |
| Employer: | Employer Address: |
| Insurance Company Name: | Group #: |
| Insurance Company Address: | Insurance Company Phone #: |
| Insurance Company City: | State: Zip: |

## MEDICAL HISTORY (Circle "Y" for Yes and "N" for No)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Y N | Allergic to Latex | Y N | Difficulty Breathing | Y N | Jaw Pain | Y N | Sexually Transmitted Diseases |
| Y N | Arthritis | Y N | Difficulty Swallowing | Y N | Joint Prosthesis | Y N | Sore Throat |
| Y N | Anemia | Y N | Headache (Recurring) | Y N | Kidney Diseases | Y N | Stomach Ulcers |
| Y N | Asthma | Y N | Heart Attack | Y N | Leukemia | Y N | Stroke |
| Y N | Bruise Easily | Y N | Heart Murmur | Y N | Loss of Consciousness | Y N | Swollen Neck glands |
| Y N | Blood Transfusion | Y N | Heart Valve (Prolapsed) | Y N | Numbness, Paralysis | Y N | Swollen Ankles |
| Y N | Cancer | Y N | Hepatitis | Y N | Pneumonia | Y N | Thyroid Disease |
| Y N | Chest Pain | Y N | High Blood Pressure | Y N | Rheumatic Heart Disease | Y N | Tuberculosis |
| Y N | Cardiac Or Vascular Surgery | Y N | HIV+/AIDS | Y N | Radiation or Chemotherapy | Y N | Urinary Tract Infection |
| Y N | Diabetes | Y N | Irregular Heart Beats | Y N | Seizures | Y N | |

| | | | |
|---|---|---|---|
| Y N | Allergies | If YES, Please list: | |
| Y N | Smoking | If YES, How Much: | For How Long: |
| Y N | Hospitalization | For What: | When: |
| Y N | Are you PREGNANT? | If YES, How Many Months? | |

List all medications you are currently taking:

Have you been dissatisfied with previous dental treatments? [ ] YES [ ] NO
If yes, please describe

I have read and understood the above questionnaire and have answered all questions truthfully to the best of my ability. If ever my health or medications change, I will inform my dentist at my next appointment. I authorized and request my insurance company to pay directly to the dentist otherwise payable to me. I authorized the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

**Email:** _____

Signature of Patient/Parent if Minor/Guardian: _____ DATE: _____

Signature of Dentist: _____ DATE: _____

## REFERRAL INFORMATION

Whom may we thank for referring you to our office? [ ] Another patient (friend) [ ] Another patient (relative)
[ ] Dental Office [ ] Yellow Pages [ ] Newspaper [ ] School [ ] Work [ ]Other _____
Name of person or office referring you to our office:

## 6-MONTH RECALL REVIEW

[ ] **Check if no change** Signature of Patient/Parent if Minor/Guardian: _____ DATE: _____

Reviewed by Dentist/Signature: _____ DATE: _____