



Patient Information Form:

Name: _____ Sex: ___ M ___ F

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Home Address: _____ Apt# _____ City: _____ Zip Code: _____

Drivers License/ID Number: _____ State: _____ Exp. Date: _____

Employer Information

Employer Name and Address: _____

Employer Phone: _____

Spouse's Name: _____ Work Phone: _____

Social Security #: _____ Date of Birth: _____

Nearest relative not living with you: _____ Phone: _____

Primary Care or Referring Physician: _____ Phone: _____

Previous Dentist: _____ Phone: _____

Whom may we contact in the case of an emergency? _____ Phone: _____

Whom may we thank for referring you to us? _____ Phone: _____

Who is responsible for this bill? _____

Insurance Information

Name of Subscriber: _____ Relationship to Patient: _____

Birthdate: _____ Social Security Number: _____

Name of employer: _____ Office Phone: _____

Insurance Company: _____ Group #: _____ Employer/ID#: _____

Insurance company address: _____ City/State: _____ Zip: _____

Do you have Secondary Insurance? ___ Yes ___ No

Name of Subscriber: _____ Relationship to Patient: _____

Birthdate: _____ Social Security Number: _____

Name of employer: _____ Office Phone: _____

Insurance Company: _____ Group #: _____ Employer/ID# _____

Insurance company address: _____ City/State: _____ Zip: _____

If this claim is accident related, please provide details of the accident:

Did you sustain an injury at work?

Yes No

Are you covered under an employer or union policy?

Yes No

Are your injuries accident related?

Yes No

Is your spouse or other family member employed?

Yes No

Are you currently employed?

Yes No

Do you have a secondary or medical insurance policy?

Yes No

Have you ever served in the military?

Yes No

Are you covered under any other healthcare plan?

Yes No

Medical History: Do you have or had any of the following (Please check all that apply)

- | | | |
|--------------------------|---------------------|---------------------------|
| Anemia | Diabetes | Lesions |
| Arthritis/ Rheumatism | Epilepsy | Mitral Valve Prolapse |
| Artificial Heart Valves | Fainting | Pacemaker |
| Artificial Joints | Glaucoma | Psychiatric Care/Problems |
| Asthma | Headaches | Radiation Treatment |
| Back Problems | Heart Murmur | Respiratory Disease |
| Bleeding Abnormalities | Heart Attack | Rheumatic Fever |
| Blood Disease | Heart Problems | Skin Rash |
| Cancer | Hemophilia | Sinus Problems |
| Chemical Dependency | Hepatitis | Stroke |
| Chemotherapy | High Blood Pressure | Thyroid Problems |
| Circulatory Problems | HIV Positive | Tobacco Habit |
| Congenital Heart Disease | Kidney Disease | Tuberculosis |

Are there any other health conditions you have that are not listed?

If so, please explain: _____

Please List all Allergies: _____

Please List all Medications you are currently taking: _____

Women Only:

Are you Pregnant? Yes No Weeks:____ Nursing? Yes No

Had an exposure to HPV? Yes No

Date of Last Dental Exam: _____ Reason for Today's Visit: _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or in the above information. **This information will be kept confidential.**

Signature _____ Date _____