Chart #: __________
Official Office Use Only

PATIENT INFORMATION

Patient Name: ____ Date: ____________________
Last First MI
SSN: ______________________ DOB: _______________ Gender: ________________ Family Status: ____________
Phone (Home): _____________________ (Cell): ______________________ (Work): _______________ Ext: _______
Best time to call: ______________________ Email: ____
Address: ____
Street Apartment #
____
City State Zip Code

HEALTH INFORMATION

Date of last dental visit: _________________ Reason for this visit: ____

Please check all that apply:

AIDS
Allergies: _____________
____
Anemia
Arthritis
Artificial joints
Asthma
Blood disease
Cancer
Diabetes
Dizziness
Epilepsy
Excessive bleeding
Fainting
Glaucoma
Growths
Hay fever
Head injuries
Heart disease
Heart murmur
Hepatitis
High blood pressure
History of drug use
Jaundice
Kidney disease
Liver disease
Mental disorders
Nervous disorders
Pacemaker
Pregnancy
Due date: __________
Radiation treatment
Respiratory problems
Rheumatic fever
Rheumatism
Sinus problems
Smoker
Packs/day: __________
Stomach problems
Stroke
Tuberculosis
Tumors
Ulcers
Venereal disease
Codeine allergy
Penicillin allergy
Other: ____________
____

Y N Have you ever had any complications following dental treatment?
If yes, please explain: ____
Y N Have you been admitted to a hospital or needed emergency care during the past two years?
If yes, please explain: ____
Y N Are you now under the care of a physician?
If yes, please explain: ____
Name of Physician: ____ Phone: __________________
Y N Do you have any health problems that need further clarifications?
If yes, please explain: ____

Please list any medications you currently take: ____
____

To the best of my knowledge, all of the preceding answers and information provide are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date: ____________________
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
Dental office Internet Advertisement School Work Other: ________________

Name of person or office referring you to our practice: ____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

The following is for: the patient's spouse the person responsible for payment

Name: ____
Male Female Married Single Child Other: ________________
Social Security #: ______________________________ Date of Birth: ______________________________
Phone (Home): ___________________ (Cell): ____________________ (Work): __________Ext: ____
Best time to call: ____________________ Email: ____
Address: ____
Street Apartment #

____
City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____________________________________ Occupation: _______________________
Address: ____ Phone: _____________
Street City State Zip

Insurance Information

Primary

Name of Insured: ____ Is insured a patient? Y N
Last ***First*** ***MI***
Insured's Birth Date: ____________________ ID #: ______________________ Group # ______________
Address: ____
Street City State Zip
Employer Name: ____
Address: ____
Street City State Zip
Patient's relationship to insured: Self Spouse Child Other: ______________________________
Insurance Plan Name and Address: ____

Secondary

Name of Insured: ____ Is insured a patient? Y N
Last ***First*** ***MI***
Insured's Birth Date: ____________________ ID #: ______________________ Group # ______________
Address: ____
Street ***City*** ***State*** ***Zip***
Employer Name: ____
Address: ____
Street ***City*** ***State*** ***Zip***
Patient's relationship to insured: Self Spouse Child Other: ______________________________
Insurance Plan Name and Address: ____