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Patient Information

Mr. / Mrs. / Ms.

First Name:_____ Last Name:_____

D.O.B.:_____ Email:_____

Address:_____ Postal Code:_____

Home #:_____ Cell #:_____ Work #:_____

Employer/School:_____

Insurance Information

Primary Insurance Company:_____

Policy #:_____ Div #:_____ Cert/ID #:_____

Policy Holder:_____ D.O.B.:_____

Secondary Insurance Company:_____

Policy #:_____ Div #:_____ Cert/ID #:_____

Policy Holder:_____ D.O.B.:_____

General Information

Chief complaint/concern:_____

When did this start?_____

Reason for leaving previous dental office?_____

_____

How did you hear of us?_____

Last dental visit?_____

Last hygiene (teeth cleaning) visit?_____

Comments:_____

_____

_____

Patient Medical History

Physician:_____ Office#:_____

1. Are you under the ongoing care of a Medical Practitioner? Yes No

   For what reason?_____

2. Have you had any serious illness or operation? Yes No

3. Have you ever been hospitalized? Yes No

4. Women, are you pregnant? Yes No

5. Have you ever required a blood transfusion? Yes No

6. Have you ever been told not to donate blood? Yes No

7. Have you ever had abnormal bleeding associated with extractions or surgery? Yes No

8. Are you allergic to any medications or local anesthetic? Yes No

9. Are you allergic to any materials resulting in hives or rash? Yes No

10.Have you had an unusual reaction to any medications, medical or dental treatment? Yes No

If so, name them:_____

11.Are you presently taking prescription medication? Yes No

If so, name them:_____

12.Are you presently taking any non-prescription medication? Yes No

If so, name them:_____

13.Have you any of the following? (Circle all that apply)

Abnormal Heart Sounds	Diabetes	HIV/AIDS	Skin Disorders
Arthritis	Epilepsy	Jaundice	Stroke
Asthma	Fainting Spells	Kidney Disease	Thyroid Problems
Blood Disorders	High Blood Pressure	Muscle Disorders	Tuberculosis
Bone Disorders	Heart Attack	Respiratory Disease	Ulcers
Cancer	Heart Disease	Rheumatic Fever	Venereal Disease
Congenital Heart Lesions	Hepatitis	Rheumatic Heart Disease	

14.Do you have any medical condition not listed above? Yes No

If so, name them:_____

Signatures

I understand that with the new privacy act, my dentist may be unable to obtain insurance information regarding available coverage; therefore, it is my responsibility to ensure I am aware of my insurance policy terms and benefit limitations.

I understand that any balances not paid by my insurance company within 90 days are my responsibility and agree to pay those balances in a timely manner. I further agree that any outstanding balance is subject to a monthly interest fee a the rate of 1.5%.

Patient/Guardian Signature:_____

Date:_____