PATIENT INFORMATION

Name_____ Sex_____

Date of Birth_____ SS#_____

Home Address_____ Phone (____)_____

City_____ State_____ Zip_____

Employed By_____

Occupation_____ Bus. Phone (____)_____

Spouse's Name_____ SS#_____

Date of Birth_____ Occupation_____

Employed by_____

Referred By_____

Name of Responsible Party_____

INSURANCE

Primary Dental Insurance:

Policy Holder Name:

Policy Holder DOB:

Policy Holder Address (If different than patient)

ID #:

Group #:

Insurance Co. Address:

Secondary Dental Insurance:

Policy Holder Name:

Policy Holder DOB:

Policy Holder Address (If different than patient)

ID #:

Group #:

Insurance Co. Address:

HIPPA Requirements

Privacy Policy ***By:***

☐ Given to Patient _____

☐ Signed Acknowledgement Received _____

Health Questionnaire

Information about your health will be confidential by this office and will be released only upon your expressed consent. Many general health factors may affect your oral health and influence our treatment. Therefore, it is important for you to complete this form accurately and in its entirety. Thank you.

Physician's Name_____ Last visit for_____

Address_____ Date_____

Are you currently under a physician's care?_____

For what condition?_____

Would you like for us to consult with him on our treatment?_____

Do you or have you ever had any of the following:

___ Any heart problems
___ High blood pressure
___ Low blood pressure
___ Circulatory problems
___ Nervous problems
___ Radiation/Chemo treatments
___ Excessive bleeding
___ Allergies to anesthetics
___ Allergies to medicine or drugs_____
___ Allergies to_____
___ Anemia
___ Arthritis
___ Asthma
___ Hip or knee replacement
___ Positive test for HIV virus
___ Thyroid
___ Fibromyalgia
___ Diabetes
___ Hepatitis A___ B____ C____
___ Kidney Disease
___ Malignancies
___ Heart murmur
___ Psychiatric care
___ Rheumatic Fever
___ Syphilis
___ Scarlet Fever
___ Sinus Problems
___ Slow healing
___ Stroke
___ Tuberculosis
___ Ulcer
___ Are you pregnant?
___ Premedication
___ PTSD
___ Epilepsy/Fainting

MEDICATIONS

_____

_____

_____

_____

_____

_____

Please describe any current medical treatment, impending operations, or any medical or dental information that may possibly affect your dental treatment._____

_____

Date_____ Your Signature_____