

Confidential Patient Information – I

Please Print Legibly:

Date: _____

PERSONAL INFORMATION

Name: _____ SS #: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work) _____

(Cell) _____ e-mail: _____

Birth date: _____ Sex: _____ Marital Status: _____ Spouse Name: _____

Occupation: _____ Referred by: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relationship: _____ SS #: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work) _____

DENTAL INSURANCE INFORMATION

Primary Insurance Co: _____

Insurance Co. Address: _____

Employee: _____ Relationship: _____ S.S. #: _____

Employer: _____ Policy #: _____

Secondary Insurance Co: _____

Insurance Co. Address: _____

Employee: _____ Relationship: _____ S.S. #: _____

Employer: _____ Policy #: _____

I understand that payment is my obligation regardless of insurance or any other third-party involvement.

SIGNATURE:

DATE:

Confidential Patient Information – II

(Please Print Legibly)

Patient Name: _____ Initial Date: _____

Update: _____

Update: _____

Update: _____

Update: _____

HEALTH INFORMATION

Personal Physician Name: _____

Personal Physician Address: _____

YES NO

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Have you been hospitalized within the past 2 years? For what? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Are you currently being treated by a physician? For what? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Are you currently taking any medicines or drugs? What? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Have you ever received counseling for excessive use of alcohol and/or prescription drugs? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Are you allergic to any drugs? What? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Are you allergic to any metals? What? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Have you ever had a skin rash or other reaction to metal jewelry? To What? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you bleed excessively upon injury? |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Are you pregnant? |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Have you ever been involved with dental/medical legal activity? |

CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE HAD

- | | | | |
|--------------|-------------------|---|----------------------------------|
| A. AIDS | F. Epilepsy | K. High Blood Pressure | P. Rheumatic Fever |
| B. Arthritis | G. Glaucoma | L. Jaundice | Q. Sexually Transmitted Diseases |
| C. Asthma | H. Heart Murmur | M. Kidney Problems | R. Stroke |
| D. Cancer | I. Heart Problem* | N. Low Blood Pressure | S. Tuberculosis |
| E. Diabetes | J. Hepatitis | O. Nervous Breakdown or Psychiatric Therapy | T. Other Diseases* |

*If you circled either I or T describe condition: _____

PERSON TO BE CONTACTED IN CASE OF EMERGENCY (OTHER THAN RELATIVE)

Name: _____

Address: _____

Telephone: (Home) _____ (Work) _____

SIGNATURE:

REVIEW BY:

DATE: