Patient Information Form

Patient Information:

Last Name:	First Name:	Middle Initial:
DOB:	Age:	Social Security Number:
Address:		
City:	State:	Zip Code:
Wireless Phone:		
Home Phone:		
E-mail:		

Primary Insurance:	Secondary Insurance:
Insurance Carrier:	Insurance Carrier:
Insurance Carrier Phone:	Insurance Carrier Phone:
Employer:	Employer:
Group Number:	Group Number:
Subscriber Name:	Subscriber Name:
Subscriber SSN:	Subscriber SSN:
Member ID:	Member ID:
DOB:	DOB:
Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child	Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Emergency Contact Information:

Name of Contact:
Phone Number:
Relationship to Patient:
May we communicate information with this individual concerning your care? ☐ Yes ☐ No

Authorization:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any of my health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payment in full of all accounts. By signing this statement, I am agreeing to responsibility of services not paid in full or part by my dental care payer.

I attest to the accuracy of the information on this page.

Patient or Guardian Signature Date

Dental History:

Reason for today's visit: | Date of last Dental visit:

Former Dentist: | Date of last Dental X-rays:

Please indicate if you current have or have had any of the following. Checking the box indicates "Yes", leaving blank indicates "No".

- ☐ Bad Breath
- ☐ Blisters on Lips or Mouth
- ☐ Burning Sensation on Tongue
- ☐ Chew on One Side of Mouth
- ☐ Clench or Grind Teeth
- ☐ Dry Mouth
- ☐ Food Collection Between Teeth
- ☐ Growths or Sore Spots in Your Mouth
- ☐ Gums Swollen, Tender or Bleeding
- ☐ Head, Neck, Jaw Pain, or Aches
- ☐ Lip or Cheek Biting
- ☐ Loose Teeth or Broken Fillings
- ☐ Mouth Breathing
- ☐ Orthodontic Treatment
- ☐ Nitrous Oxide
- ☐ Periodontal Treatment
- ☐ Sensitivity to Pressure, Cold, Heat or Sweets
- ☐ Smokeless Tobacco
- ☐ Cigarette, Pipe, or Cigar Smoking
  If yes, Frequency: _____ Quantity: _____

Do you have to take pre-medication prior to receiving dental treatment? ☐ Yes ☐ No
If Yes, please explain:

Have you ever had an allergic reaction to Novocaine, local or general anesthetics? ☐ Yes ☐ No
If Yes, please explain:

Have you ever had trouble from previous dental care? ☐ Yes ☐ No
If Yes, please explain:

Medical History:

Physician's Name: | Physician's Address:

Date and reason for last visit:

Please indicate if you current have or have had any of the following. Checking the box indicates "Yes", leaving blank indicates "No".

Allergies
- ☐ Aspirin
- ☐ Latex
- ☐ Penicillin
- ☐ Other Allergies (List Below)

Conditions
- ☐ Abnormal Bleeding
- ☐ Alcohol Use/Consumption
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma:
  Required Hospitalization ☐
  Have you used steroids? ☐
  Date of Last Episode
  _____
- ☐ Blood Transfusion
- ☐ Bisphosphonates (Fosomax, Actonel, Boniva, Reclast, Didronel, Zometa)
- ☐ Blood Disease, Clotting Disorder
- ☐ Blood Thinners
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Contact Lenses
- ☐ Cortisone Treatments
- ☐ Cough, Persistent or Bloody
- ☐ Diabetes: A1C _____
  Date Taken _____
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis: Type _____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Any Immune Deficiency
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Pacemaker
- ☐ Pregnant/Nursing:
  Due Date _____
- ☐ Radiation Treatments
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sinusitis
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Sickle Cell Anemia
- ☐ Skin Rash
- ☐ Slow Healing Wounds
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or Growth on Head and/or Neck
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Weight Loss, Unexplained
- ☐ Other Conditions (Explain Below)

Other Allergies: List all additional allergies you have below.

_____ _____
_____ _____
_____ _____

Other Conditions: (serious illnesses, operations and hospitalizations)

_____
_____
_____

Medications: List any medications you are taking below.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Authorization and Release:

I have read and answered the above questions to the best of my knowledge.

_____
Patient/Guardian Signature **Date**

_____
Doctor Signature **Date**