

**Patient Information**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Last, First MI (Preferred Name) Gender: \_\_\_\_\_ Family Status: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ email: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Street Apartment #  
 City State Zip Code

**Health Information**

**Have you ever had any of the following? Please check those that apply:**

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> AIDS                | <input type="checkbox"/> Excessive Bleeding   | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Allergies _____     | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Mental Disorders     | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Nervous Disorders    | <input type="checkbox"/> Tumors             |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Growths              | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Artificial Joints   | <input type="checkbox"/> Hay Fever            | <input type="checkbox"/> Pregnancy            | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Head Injuries        | Due date: _____                               | <input type="checkbox"/> Codeine Allergy    |
| <input type="checkbox"/> Blood Disease       | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Radiation Treatment  | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Respiratory Problems | OTHER:                                      |
| <input type="checkbox"/> Diabetes Type _____ | <input type="checkbox"/> Hepatitis Type _____ | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Latex allergy      |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Rheumatism           | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Jaundice             | <input type="checkbox"/> Sinus Problems       |   |
|  | <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Stomach Problems     |   |

- Have you been advised by your physician to pre-medicate prior to dental treatments?  Yes  No

Have you ever had any complications following dental treatment?  Yes  No

If yes, please explain: \_\_\_\_\_

- Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No

If yes, please explain: \_\_\_\_\_

- Are you now under the care of a physician?  Yes  No

If yes, please explain: \_\_\_\_\_

• Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

- Do you have any health problems that need further clarification?  Yes  No

If yes, please explain: \_\_\_\_\_

- Please list any medications, including non-prescription drugs, taken on a regular basis \_\_\_\_\_

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

\_\_\_\_\_  
 Signature of patient, parent or guardian Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

### 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 #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Address: \_\_\_\_\_  
Street \_\_\_\_\_ Apartment # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### Employment Information

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

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street \_\_\_\_\_ City, State Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

### Insurance Information

#### Primary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No  
Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_  
\_\_\_\_\_

#### Secondary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No  
Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: *«Sins Name»* \_\_\_\_\_  
\_\_\_\_\_

I understand that I am responsible for the timely payment of my account. A late fee and/or interest at the rate of 1.5% per month on unpaid balances may be charged on all account exceeding 90 days unless other financial arrangements have been agreed upon. Accounts that remain unpaid for more than 120 days may be subjected to collection proceedings and any costs related to such collection attempts will be added the account balance.

\_\_\_\_\_  
Signature of patient, parent or guardian Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Signature of guarantor of payment/responsible party Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_