Patient Information

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____

_____ (City) _____ (State) _____ (Zip Code)

Referral Information

Name of person, office or other source referring you to our practice:

_____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Driver's License #: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) ____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Employment Information

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

Employer Name: _____ Phone: _____

Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Insurance Information

Primary Dental

Name of Insured: Last First MI

Insured's Birth Date: ID #. Group #.

Insured's Address:

City State Zip Code

Insured's Employer Name:

Employer Address:

City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

Insurance Address:

City State Zip Code

Secondary Dental

HIPAA. NOTICE OF PRIVACY PRACTICES. Effective date May 16th 2016.

* ☐ I acknowledge reciept of a copy/e-copy of this office's Notice of Privacy Practices.

Full Name

*

Signature and Date

Signature: _____ Date:

Response Date:

Medical & Dental History Form

Patient Name: _____ _____ _____ _____

Last First MI Preferred Name

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health?

◯ Yes ◯ No

Within the past year, have there been any changes in your general health?

◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam?

_____

Your Primary Care Physician's name, address, & phone number:

_____

Please mark any of the following to indicate Yes in response to the question:

☐ Have you ever had complications following dental treatment?

☐ Are you currently under the care of a physician due to a specific condition?

☐ Have you been hospitalized within the last 5 years due to a surgery or illness?

☐ Are you currently taking any prescription or non-prescription medications?

☐ Do you use tobacco (smoking or chewing)?

☐ Do you require the use of corrective lenses (contacts or glasses)?

☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

_____

WOMEN ONLY: Are you pregnant?

◯ Yes ◯ No

If Yes, when is the due date?

Please indicate if you have experienced any of the following:

- ☐ Allergies
- ☐ Anemia
- ☐ Asthma
- ☐ Codeine Allergy
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Hepatitis
- ☐ HIV
- ☐ Latex allergy
- ☐ Mental Disorders
- ☐ Other
- ☐ Pregnancy
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Sulfa Allergies
- ☐ Tumors
- ☐ Allergies
- ☐ Arthritis
- ☐ Blood Disease
- ☐ Diabetes
- ☐ Excessive Bleeding
- ☐ Growths
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Liver Disease
- ☐ Mitral ValveProlapse
- ☐ Pacemaker
- ☐ Pre-Med
- ☐ Rheumatic Fever
- ☐ Stomach Problems
- ☐ Tetracycline Allergy
- ☐ Ulcers
- ☐ Allergy Prophy paste
- ☐ Artificial Joints
- ☐ Cancer
- ☐ Dizziness
- ☐ Fainting
- ☐ Hay Fever
- ☐ Heart Murmur
- ☐ HIV
- ☐ Kidney Disease
- ☐ Low blood pressure
- ☐ Nervous Disorders
- ☐ Penicillin Allergy
- ☐ Radiation Treatment
- ☐ Rheumatism
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Venereal Disease

Do you have any other health issues or allergies?