DATE______________________

PLEASE LET US KNOW HOW YOU WERE REFERRED TO OUR OFFICE. LIST MULTIPLE SOURCES IF APPLICABLE.

DOCTOR PATIENT PAPER/MAGAZINE Google Keyword_______________________

NAME OF REFERENCE____

PATIENT INFORMATION

Name _______________________________Birth date ________Age(___) Sex: Male Female
Address________________________________City____________________State_________Zip_______
Home Phone (____)______________ Work Phone (____)________________Cell (____)_______________
E-mail address____
If patient is a student, Name of School ____
Person to contact in case of emergency: Name____
Phone Number: (___)______________ Relationship to Patient:______________________________

RESPONSIBLE PARTY

Name____
Relationship to Patient__________________
Address_________________________________City____________________State_________Zip_______Home Phone
(____)______________ Work Phone (____)________________Cell (____)_______________
E-mail address ____
Check the Appropriate Box: Single Married Divorced Widowed Separated Domestic Partner
Drivers License # ________________________________ State_____________ Exp Date _____________

INSURANCE INFORMATION

If you wish to have our office submit your dental claims for you, please fill this section out ***completely.***

Primary Dental Insurance
Name of Policy Holder________________________________ Relationship to Patient________________
Birth date_____________________ Social Security /ID#____
Employer____ Work Phone_(____)________________
Insurance Company____ Group #______________________
Address_______________________________________City_________________State_____Zip_________
Phone (_____)______________

Secondary Dental Insurance
Name of Policy Holder_________________________________ Relationship to Patient_________________
Birth date______________________ Social Security/ID # ____
Employer____ Work Phone_(____)________________
Insurance Company____ Group #______________________
Address_______________________________________City_________________State_____Zip_________
Phone (_____)______________

DENTAL HISTORY

Reason for today's visit________________________________ Date of last dental visit_________________

Former/Current Dentist______________________________ Date of last dental X-rays_________________

Address_______________________City______________State____Zip________Phone(____)___________

Has Patient had any of the following:

__ Bad breath
__ Grinding teeth
__ Bleeding gums
__ Loose teeth or broken fillings

__ Clicking or popping jaw
__ Periodontal treatment
__ Food collection between teeth
__ Sores or growths in mouth

Sensitivity:
__ Sensitivity when biting
__ Sensitivity to cold
__ Sensitivity to heat
__ Sensitivity to sweets

MEDICAL HISTORY

Physician's Name_______________________________________ Date of last visit_______________

Address_______________________City______________State____Zip________Phone(____)___________

Has patient ever had any serious illnesses or operations? Yes No ------ If yes, describe type and date:

____

Check if patient has had any of the following: **(If none, indicate here:) NONE**________ (initials)

__ADD/ADHD
__AIDS/HIV
__Anemia
__Asthma
__Cancer
__Cerebral Palsy
__Chicken Pox
__Diabetes
__Epilepsy/Seizures

__Eye Disorders
__Extreme nervousness
__Hearing Problems
__Heart Ailments
__Hemophilia
__Hepatitis
__Hives
__Kidney Problems
__Learning Disability

__Liver Problems
__Measles
__Mental Retardation
__Mononucleosis
__Rheumatic Fever
__Psychiatric Care
__Sinus Problems
__Physical Handicap
__Tonsillitis

__Thyroid Disorders
__Ulcer or Colitis

Other/Details:
____
____
____
____
____

Medications:

List medications patient is taking and
Correlating diagnosis:__________________________
____
____
____

Allergies:
____
____
____
____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my/the patient's health.

Signature____Date___________

Relationship_____________________________

****

Reviewed by Doctor______________________________