PATIENT INFORMATION

(This information is necessary for our files, it will be considered confidential)

Date_____

Gender: ❑**Female** ❑**Male** ❑**Single** ❑**Married** ❑**Child**

Birthdate _____**Social Security #** _____

Patient's Name _____

Street Address_____

City _____**State** _____**Zip Code**_____

Phone H) _____**W)** _____**C)** _____

E-mail:_____

INSURANCE INFORMATION

Insured Person's Name _____

Birthdate _____ **Social Security #** _____

Employers Name _____

Insurance Company Name _____

Member Id # _____**Group #**_____

Do you have other dental coverage? ❑**Yes** ❑ **No** **If yes, complete the following:**

Insured Person's Name _____

Insurance Company Name _____

Member Id Number _____

HEALTH INFORMATION

- ❑Adenoids Removed
- ❑Anemia
- ❑Arthritis
- ❑ Asthma
- ❑ Cerebral Palsy
- ❑ Chronic Ear Problems
- ❑ Chronic Sinus
- ❑ Circulatory Problems
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Excessive Bleeding
- ❑ Hepatitis
- ❑Heart Problems
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ HIV
- ❑Joint Replacement (Indicate below)
- ❑ Kidney Problem
- ❑Low Blood Pressure
- ❑ Malignancies
- ❑ Nervous Problems
- ❑ Radiation Treatments
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑Tonsils Removed
- ❑Tuberculosis

Other health complications not listed above:

_____

_____

Are you pregnant? ❑Yes ❑No

Allergy Indication: ❑ Penicillin ❑Codeine ❑ Local Anesthetics ❑ Latex

List all medications you are currently taking:

_____

_____

_____

Name of previous dentist _____

Date of last visit _____

I hereby authorize the doctor to provide any treatment, medication, or therapy that may be necessary in connection with the dental care of the patient above. I also understand that prior to treatment a full explanation of the procedure(s) involved will be given by the doctor and his or her staff. I agree to payment in full for all services rendered by this office not covered by insurance.

Signature_____

Relationship to patient _____ **Date:** _____