

PATIENT INFORMATION

Date _____

Welcome to our office. We will do our best to make your appointments as convenient and pleasant as possible. If at any time you have any questions regarding your treatment, your appointments, or fees please feel free to ask. Your kindness in furnishing the following information will be appreciated and will be used in strict confidence to prepare your clinical chart.

Patient's Name _____ Date of Birth _____

Home Address _____ Home Phone _____

Cell Phone _____

City _____ State _____ Zip Code _____

Social Security # _____ Male _____ Female _____

Marital Status Single _____ Married _____ Widowed _____ Divorced _____

Employed by _____ Occupation _____

Business Address _____ Business Phone _____

City _____ State _____ Zip Code _____

Person responsible for payment of services rendered _____

Address _____ Phone _____

City _____ State _____ Zip Code _____

Spouse, nearest relative or other _____

Please check if you have any of the following:

MEDICAL HISTORY:

_____ Bleeding Problems

_____ Abnormal Blood Pressure

_____ Diabetes

_____ Joint Replacement

_____ Tuberculosis

_____ Rheumatic Fever

_____ Hepatitis

_____ Heart Disease

_____ HIV

_____ Mitral Valve Prolapse

ALLERGIES:

Penicillin? _____

Codeine? _____

Novocaine? _____

Other? _____

Are you presently taking any medication or drugs? If so, please list _____

Name of your physician _____ Are you under his care now? _____ Yes _____ No

Address _____ Phone _____

Referred by _____ Purpose of this visit _____

How long since you have been to a dentist? _____ What was done? _____

If you have a denture or partial what year was it made? _____

CHECK METHOD OF PAYMENT YOU PREFER:

_____ Payment in full

_____ Visa

_____ Mastercard

_____ American Express

Signature _____

INSURANCE INFORMATION SHEET
Primary Dental Insurance Coverage

Subscriber Name: _____ Relation to Patient: _____

Address: _____

SS No: _____ Employer: _____

DOB: _____ Address: _____

Plan Name: _____ Group No: _____

Insurance Co: _____

Address: _____

Secondary Dental Insurance Coverage

Subscriber Name: _____ Relation to Patient: _____

Address: _____

SS No: _____ Employer: _____

DOB: _____ Address: _____

Plan Name: _____ Group No: _____

Insurance Co: _____

Address: _____

Your insurance is filed as a courtesy. You are responsible for remaining balance due.

Signature: _____ Date: _____