PLEASE PRINT

PATIENT INFORMATION - ADULT

Date _____ Cell # _____

Patient Name _____ Alternate Phone # _____

Street Address _____ City _____ State _____ Zip _____

Marital Status _____ Birthdate _____ Age _____

Email Address _____

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

City _____ State _____ Length of Employment _____

Spouses Name _____ Spouses Birthdate _____

Spouse Employed by _____ Occupation _____

Business Address _____ Business Phone _____

City _____ State _____ Length of Employment _____

Who is responsible for this account? _____ Relationship to Patient _____

Patient's Social Security # _____ Spouses Social Security # _____

Patients Drivers License # _____ Spouses Drivers License # _____

Name of Dental Insurance Company _____ Group # _____

In case of emergency, who should be notified? _____ Phone # _____

How long since your last dental visit? _____ Name of Referral _____

MEDICAL HISTORY

Physicians Name _____

Are you in good health? (YES / NO)

Are you currently under the care of a physician? (YES / NO)

If yes, for what condition?

_____

_____

Are you currently under medication? (YES / NO)
If yes, please list _____

_____

Have you had a blood transfusion in the past 10 years? (YES/NO)

	YES	NO		YES	NO		YES	NO
High Blood Pressure			Epilepsy			Back Problems		
Rheumatic Fever			Asthma			Cancer		
Heart Murmur			Diabetes			Psychiatric Care		
Other Heart Problems			Fainting			Allergies to Anesthetics		
A.I.D.S./H.I.V.			Excessive Bleeding			Unable to use Alcohol Base Products		
Hepatitis			Nervous Disorders			A.I.D.S. or Other Immunosuppressive Disorders		
Venereal Disease			Chronic Headaches			Chemical Dependency		
Drug/Alcohol Abuse			Swollen or Bleeding Gums			Other		
Tuberculosis			Artificial Heart Valves or Joints					

Are you allergic or sensitive to any medication? (example: Novocain, Penicillin, etc)

Please List _____

Women: Are you pregnant? Yes_____ No_____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____

Name of Insurance Company

And assign directly to Dr. _____ **all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.**

_____ _____

Date **Signature**

FOR OFFICE USE ONLY

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? Yes __________ No __________

For what conditions? ____

Are you taking any medications? (YES / NO) If so, what ______________________________

______________________ Date

______________________ Signature

______________________ Date

______________________ Dentist Signature

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? Yes __________ No __________

For what conditions? ____

Are you taking any medications? (YES / NO) If so, what ______________________________

______________________ Date

______________________ Signature

______________________ Date

______________________ Dentist Signature

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? Yes __________ No __________

For what conditions? ____

Are you taking any medications? (YES / NO) If so, what ______________________________

______________________ Date

______________________ Signature

______________________ Date

______________________ Dentist Signature