PATIENT'S MEDICAL INFORMATION

Patient Name____Age__________
Physician's Name______________________________ City and State______________
Please list any serious illness or major surgeries______________________________
All current medical treatment____
____
List all medications currently taking____________________________________
____
Are you currently taking or have taken bisphosphonate medications (circle) Yes or No

Please circle any of the following conditions that apply:

Glaucoma	Hives	Liver Disease	Nervous or Mental Disorder
Heart Disease	Chemotherapy	Hay Fever	Gastro-Intestinal Disease
Rheumatic Fever*	Cancer	Thyroid Disease	High Blood Pressure
Heart Murmur*	Stomach Ulcer	Radiation Therapy	Low Blood Pressure
Lung Disease	Diabetes	Hepatitis (Type) ____	Chronic Sinus Condition
Blood Disease	Epilepsy	Kidney Disease	Artificial Joint Replacement*
Asthma	Arthritis	Lupus	AIDS, AIDS Complex or HIV

*Have you been told by your physician that you need premed antibiotic before dental treatment? Yes No

Allergies Please read each question carefully before answering

Are you allergic to aspirin? Yes No
Are you allergic to penicillin? Yes No
Are you allergic to latex? Yes No
Have you ever had any reaction to local anesthetic? Describe____________________
____
Please List anything else to which you are allergic____________________________
____
Please describe any adverse effects from taking any drug, medication, antibiotic or anesthetic
____

General Information

Can you walk up a flight of stairs without getting out of breath or having chest pains? Yes No
Do you bruise easily? Yes No
Do you bleed abnormally? Describe- Yes No
Are you on a medically supervised diet? Yes No
Is this treatment for injuries sustained in an accident?
Type of accident ________________________
Date of accident ________________________

Women Only

Are you or may you be pregnant? Yes No Weeks____________
Are you nursing? Yes No If yes, how old is the baby?________________

The above information is true and correct to the best of my knowledge. I will inform the doctor of any changes in my health or medications. I consent to be examined and to have x-rays taken of my teeth if needed.
Signed____Date________________
Initial and Date for Updates________________ ______________ _____________________ _________

PATIENT INFORMATON

Name: ____Nickname:_____________

Address: ____

City: ________________________________State:______________________Zip:_________________

Home phone: (____) ______________________Work Phone: (____) ____________________________

Cell Phone: (____) ________________________Email: _______________________________________

Social Security: _______________________________ Date of Birth: _____________________________

Marital Status: _______________________________Referred by Dr. : ___________________________

Employed by: _________________________________ Occupation: ______________________________

Employer's address: ____

City, State & Zip

If full time student, Name of School: ____

Payment for patient's portion if today's services will be made by:

CASH _______ CHECK______ VISA______ MASTERCARD_____DISCOVER______

DENTAL INSURANCE INFORMATION:

Primary Insurance:

Ins. Co. Name: _____________________

Address: __________________________

City: ________ State: _____Zip:________

Phone: (___) _______________________

Name of Subscriber: _________________

Subscriber #: ___________Grp#: _____

Secondary Insurance:

Ins.Co. Name: ______________________

Address: __________________________

City: ________State:______Zip:________

Phone: (___) _______________________

Name of Subscriber: _________________

Subscriber #:____________Grp#: ____

PLEASE SIGN THE FOLLOWING RELEASES FOR BILLING INSURANCE:

Assignment of Benefits:

I hereby authorize payment directly to the Provider for services rendered.

____

Patient, Parent or Guarantor's Signature

Release of Information:

I hereby authorize the release of any dental information Necessary to process this claim.

____

Patient, Parent or Guardian's Signature

Patient's Spouse or Parent- complete only if patient is NOT subscriber and/or is a dependent child

Name: ____________________________________ DOB: ___________________________

Address: ____________________________________City:________State:_______Zip:______

Social Security Number: ____

Employer: _________________________ Address: _______________________________________

Updates: (initials and date) ____________________ ______________________ ________________