



Account #: _____ Date: _____

Patient Information Form

Please print clearly and complete all fields thoroughly. Thank you!

PATIENT INFORMATION

First name: _____ Last: _____ Middle: _____

Preferred name: _____ Date of Birth: _____ SSN: _____

Address: _____ (Home / Condo / Apartment) | Apt. #: _____

City, State, ZIP Code: _____

Email: _____ Cell phone: (_____) _____

Home phone: (_____) _____ Can we text you? (Y / N)

Patient's Sex: (Female / Male) | Marital Status: (Single / Married / Divorced / Widow / Separated)

Spouse's name – First: _____ Last: _____

Spouse's Date of Birth: _____

Whom may we thank for referring you? _____

Patient's Employer: _____ Job Title: _____

Employer's Address: _____

Patient's Work Phone: (_____) _____

Self Employed? ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION

First name: _____ Last: _____

Phone: (____) _____ Relationship to Patient: _____

Address: _____

Following HIPAA rules and regulations, are we allowed to provide this individual with details about your appointments, pending treatment, referrals, balances, financial information (including past due balances), etc. either in person or over the phone?

☐ Yes ☐ No

FINANCIAL INFORMATION

Person financially responsible for this account: ☐ Patient (same info as above) ☐ Someone else (fill out info below)

First name: _____ Last: _____ Middle: _____

Relationship to patient: _____ Date of Birth: _____ SSN: _____

Address: _____ (Home / Condo / Apartment) | Apt. #: _____

City, State, ZIP Code: _____ Sex: (F / M) | Can we text you? (Y / N)

Cell phone: (____) _____ Home phone: (____) _____

Self Employed? ☐ Yes ☐ No

Employer: _____ Job Title: _____

Employer's Address: _____

Work Phone: (____) _____

- Please complete next page -

- Continued from Page 1 -

INSURANCE POLICY HOLDER

PRIMARY INSURANCE

Subscriber: _____
Subscriber ID: _____
Subscriber SSN: _____
Subscriber Date of Birth: _____
Patient's relationship to Subscriber (circle one below):
Self / Spouse / Child / Other
Insurance Company: _____
Insurance Phone #:
() _____
Group Name: _____
Group #: _____
Subscriber's Employer: _____
Subscriber's Job Title: _____
Subscriber's Work Address: _____
Subscriber's Work Phone #: _____

SECONDARY INSURANCE

Subscriber: _____
Subscriber ID: _____
Subscriber SSN: _____
Subscriber Date of Birth: _____
Patient's relationship to Subscriber (circle one below):
Self / Spouse / Child / Other
Insurance Company: _____
Insurance Phone #:
() _____
Group Name: _____
Group #: _____
Subscriber's Employer: _____
Subscriber's Job Title: _____
Subscriber's Work Address: _____
Subscriber's Work Phone #: _____

SIGNATURE & INFORMATION VERIFICATION

I affirm that the information provided on this form is complete and accurate to the best of my knowledge.

Print Patient's name: _____

Signature of Patient: _____ Date: _____

(or)

Print Legal Guardian/Responsible Party's name: _____ Relationship: _____

Signature of Legal Guardian/Responsible Party: _____ Date: _____



Account #: _____ Date: _____

Medical History Form

Please print clearly and complete all fields thoroughly. Thank you!

GENERAL HEALTH

Physician's Name: _____ Date of last physical: _____

Have you ever had any of the following? (Please check all boxes that apply)

- | | | |
|--|---|--|
| ☐ Heart Murmur | ☐ Epilepsy | ☐ Special Diet |
| ☐ High Blood Pressure | ☐ Headaches | ☐ Swollen Neck Glands |
| ☐ Low Blood Pressure | ☐ Hepatitis, Jaundice, Liver Disease | ☐ Rheumatic Fever |
| ☐ Circulatory Problems | ☐ Cancer | ☐ Sinus Problems |
| ☐ Sleep Apnea / Snoring | ☐ Psychiatric Care | ☐ AIDS / HIV |
| ☐ Radiation Treatments | ☐ Mitral Valve Prolapse | ☐ Thyroid Disease |
| ☐ Artificial Heart Valves or Joints | ☐ Allergies to Anesthetics | ☐ Stroke |
| ☐ Recent Weight Loss | ☐ Allergies to Medicines or Drugs | ☐ Ulcer |
| ☐ Back Problems | ☐ General Allergies | ☐ Venereal Disease |
| ☐ Diabetes | ☐ Blood Disease | ☐ Chemical Dependency |
| ☐ Respiratory Disease | ☐ Arthritis | ☐ Hemophilia |

Do you have any drug allergies, or have you ever had an adverse reaction to any medication? ☐ Yes ☐ No
If so, what?

Have you ever responded adversely to medical or dental treatment? ☐ Yes ☐ No

Are you currently taking any medication? ☐ Yes ☐ No
If so, please list your medications here:

Are you currently under the care of a physician? ☐ Yes ☐ No
For what conditions?

If the patient is a child, what is his/her weight? _____ lbs.

Women: Do you suspect that you are pregnant? ☐ Yes ☐ No | Are you nursing? ☐ Yes ☐ No

Is there anything else we should know about your medical history? Please describe: _____

SIGNATURE & INFORMATION VERIFICATION

I affirm that the information provided on this form is complete and accurate to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his staff responsible for errors or omissions that I may have made in the completion of this form.

Print Patient's name: _____

Signature of Patient: _____ Date: _____

(or)

Print Legal Guardian/Responsible Party's name: _____ Relationship: _____

Signature of Legal Guardian/Responsible Party: _____ Date: _____

