Confidential Patient Information – I

(Please Print Legibly)

Date: ______________________

Personal Information

Name: ______________________ SS #: ______________________

Address: ______________________

City: ______________________ State: ______ Zip: ______________

Telephone: (Home) ______________________ (Work) ______________________

(Cell) ______________________ e-mail: ______________________

Birth date: ____________ Sex: _____ Marital Status: ________ Spouse Name: ______________________

Occupation: ______________________ Referred by: ______________________

Person Responsible for Account

Name: ______________________ Relationship: ____________ SS #: ____________

Address: ______________________

City: ______________________ State: ______ Zip: ______________

Telephone: (Home) ______________________ (Work) ______________________

Dental Insurance Information

Primary Insurance Co: ______________________

Insurance Co. Address: ______________________

Employee: ______________________ Relationship: __________ S.S. #: ______________________

Employer: ______________________ Policy #: ______________________

Secondary Insurance Co: ______________________

Insurance Co. Address: ______________________

Employee: ______________________ Relationship: ____________ S.S. #: ______________________

Employer: ______________________ Policy #: ______________________

I understand that payment is my obligation regardless of insurance or any other third-party involvement.

______________________________________ ______________________

PATIENT'S NAME **DATE**

Patient Information (Elective)

We would like to know more about you. Please fill in the following information to help us get to know you better.

Name: ______________________________ Date: ____________

Birthplace: ______________________________

Where did you grow up? ______________________________

____

Where have you lived as an adult? ______________________________

____

____

What is your marital status? ______________________________

Do you have children?__________ What are their ages? ______________________________

____

____

What is your educational background? ______________________________

____

____

What is your vocation? ______________________________

What are your hobbies? ______________________________

____

____

What special interests or activities do you enjoy? ______________________________

____

____

Is there anything special you would like us to know about you? ______________________________

____

____

____

____

____

____

Confidential Patient Information – II

(Please Print Legibly)

Patient Name: ______________________ Initial Date: ______________________

Updated: ______________________

Updated: ______________________

Updated: ______________________

Health Information

Personal Physician Name: ______________________

Personal Physician Address: ______________________

YES	NO	
❑	❑	1. Have you been hospitalized within the past 2 years? For what? ____________
❑	❑	2. Are you currently being treated by a physician? For what? ____________
❑	❑	3. Are you currently taking any medications, drugs, or natural supplements? What? ____________
❑	❑	4. Have you ever received counseling for excessive use of alcohol and/or prescription drugs?
❑	❑	5. Are you allergic to any drugs? What? ____________
❑	❑	6. Have you ever had a skin rash or other reaction to metal jewelry? To What? ____________
❑	❑	7. Are you allergic to any metals? What? ____________
❑	❑	8. Do you bleed excessively upon injury?
❑	❑	9. Are you pregnant?
❑	❑	10. Have you ever been involved with dental/medical legal activity?

Circle Any of the Following Conditions That You Have Had or Now Have

A. Acid Reflux
B. AIDS
C. Arthritis
D. Asthma
E. Cancer
F. Diabetes
G. Epilepsy
H. Glaucoma
I. Heart Murmur
J. Heart Problem*
K. Hepatitis
L. High Blood Pressure
M. Jaundice
N. Kidney Problems
O. Low Blood Pressure
P. Nervous Breakdown or Psychiatric Therapy
Q. Osteoporosis
R. Rheumatic Fever
S. Sexually Transmitted Diseases
T. Stroke
U. Tuberculosis
V. Other Diseases*

Person to Be Contacted in Case of Emergency (Other Than Relative)

Name: ______________________

Address: ______________________

Telephone: (Home) ______________________ (Work) ______________________