

**Confidential Patient Information – I**

Date: \_\_\_\_\_

**PATIENT INFORMATION** (Please Print Legibly)

Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_

(Cell): \_\_\_\_\_ **EMAIL:** \_\_\_\_\_

Birth Date: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Spouse Name: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Referred by: \_\_\_\_\_

**PERSON RESPONSIBLE FOR ACCOUNT**

Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_

(Cell): \_\_\_\_\_ Email: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Spouse Name: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

Primary Insurance Co: \_\_\_\_\_ Telephone: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Birth Date: \_\_\_\_\_ SS#: \_\_\_\_\_ ID#: \_\_\_\_\_

Employer: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary Insurance Co: \_\_\_\_\_ Telephone: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Birth Date: \_\_\_\_\_ SS#: \_\_\_\_\_ ID#: \_\_\_\_\_

Employer: \_\_\_\_\_ Group #: \_\_\_\_\_

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

SIGNATURE:	DATE:
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**Confidential Patient Information – II**

Patient Name: \_\_\_\_\_

**HEALTH INFORMATION**

Physician Name: \_\_\_\_\_

Physician Address: \_\_\_\_\_

YES NO

- Have you been hospitalized within the past 2 years? For what? \_\_\_\_\_
- Are you currently being treated by a physician? For what? \_\_\_\_\_
- Are you currently taking any medicines or drugs? What? \_\_\_\_\_
- Have you ever received counseling for excessive use of alcohol and/or prescription drugs?
- Have you ever had a joint replacement? What joint and when? \_\_\_\_\_
- Are you allergic to any drugs? What? \_\_\_\_\_
- Are you allergic to any metals? What? \_\_\_\_\_
- Have you ever had a skin rash or other reaction to metal jewelry? To what? \_\_\_\_\_
- Do you bleed excessively upon injury?
- Are you pregnant?
- Have you ever been involved with dental/medical legal activity?

**CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE HAD**

- |              |                   |                                    |                    |
|--------------|-------------------|------------------------------------|--------------------|
| A. AIDS      | F. Epilepsy       | K. High Blood Pressure             | P. Rheumatic Fever |
| B. Arthritis | G. Glaucoma       | L. Jaundice                        | Q. STD             |
| C. Asthma    | H. Heart Murmur   | M. Kidney Problems                 | R. Stroke          |
| D. Cancer    | I. Heart Problem* | N. Low Blood Pressure              | S. Tuberculosis    |
| E. Diabetes  | J. Hepatitis      | O. Nervous Breakdown/<br>A / B / C | T. Other Diseases* |
|              |                   | Psychiatric Therapy                |                    |

\*If you circled either I or T, describe condition: \_\_\_\_\_

**PERSON TO BE CONTACTED IN CASE OF EMERGENCY (OTHER THAN RELATIVE)**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_

(Cell): \_\_\_\_\_

**24 HOUR CANCELLATION / NO SHOW POLICY** – \$75 fee will be charged for any no shows or changes to appointments without at least 24 hours prior notice.

Collection and attorney fees will be charged on any unpaid balance.

SIGNATURE:	REVIEWED BY:	DATE:
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