

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 authorize GOODMAN DENTAL CENTER to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents. I authorize payment of dental benefits otherwise payable to me, directly to GOODMAN DENTAL CENTER. I agree to be responsible for all charges for dental services and materials not paid by my dental plan.

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
A / B / C | O. Nervous Breakdown/
Psychiatric Therapy | T. Other Diseases* |

*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 – \$50 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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