Confidential Patient Information – I

(Please Print Legibly)

Date: _____

Personal Information

Name: _____ SS#: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____ (Home) _____(Work)
Cell Phone: _____ 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 Company: _____
Insurance Company Address: _____
Employee: _____ Relationship: _____
Employee Date of Birth: _____ SS# or Employee ID#: _____
Employer: _____ Policy # or Group #: _____
Secondary Insurance Company: _____
Insurance Company Address: _____
Employee: _____ Relationship: _____
Employee Date of Birth: _____ SS# or Employee ID#: _____
Employer: _____ Policy # of Group #: _____

I understand that payment is my obligation regardless of insurance or any other third party involvement. I understand that if my account defaults, I may be subject to additional collection fees.

Signature: **Date:**

Confidential Patient Information – II

(Please Print Legibly)

Patient Name: _____ Initial Date: _____

Update: _____

Update: _____

Update: _____

Update: _____

Health Information

Physician Name: _____

Physician Phone Number: _____ Address: _____

YES NO

1. Have been hospitalized within the past 2 years?
   If yes, what for? _____
2. Are you currently being treated by a physician?
   If yes, what for? _____
3. Are you currently taking any medications or drugs?
   If yes, please list: _____
4. Have you ever received counseling for excessive use of alcohol and / or prescription drugs? _____
5. Are you allergic to any medications?
   If yes, please list: _____
6. Are you allergic to any metals?
   If yes, which ones: _____
7. Have you ever had a skin rash or other reaction to metal jewelry? _____
8. Do you bleed excessively upon injury? _____
9. Are you pregnant? _____
10. Have you ever been involved with a dental / medical legal activity?

Circle Any of the Following Conditions That You Have Had

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

* If you circled either I or T describe condition:

_____

_____

_____

Person To Contact In Case of Emergency

Name: _____ Relationship: _____

Address: _____

Telephone: _____ Cell Phone: _____

Signature:	Reviewed by:	Date: