PATIENT INFORMATION FORM

LAST NAME: _____ FIRST NAME: _____

MIDDLE NAME/INITIAL: _____ PREFERRED NAME: _____

HOME ADDRESS: _____CITY\STATE\ZIP_____

HOME PHONE: _____WORK PHONE: _____CELL PHONE: _____

DOB: ____/____/____ SS#: ____-____-____SEX: _____

EMPLOYER _____ E-MAIL ADDRESS: _____

MARITIAL STATUS: _____ REFERRING PATIENT: _____

DENTAL INSURANCE INFORMATION

SUBSCRIBER NAME & ADDRESS: _____

RELATION TO PATIENT: _____ SS#: ____-____-____ DOB:___/___/___.

SUBSCRIBER EMPLOYER NAME & ADDRESS: _____

DENTAL INSURANCE CO. NAME & ADDRESS: _____

GROUP #: _____ YEARLY DEDUCTIBLE: _____ YEARLY MAXIMUM: _____

RESPONSIBLE PARTY FOR PATIENT:
(if different than information for patient)

Name & Address: _____

Signature: _____ **Date**: _____

Y	N	Conditions
__	__	Abnormal Bleeding
__	__	Alcohol Abuse
__	__	Drug Abuse
__	__	Anemia
__	__	Angina Pectoris
__	__	Arthritis
__	__	Artificial Joints
__	__	Artificial Heart Valve
__	__	Asthma
__	__	Blood Transfusion
__	__	Cancer-Chemo \ Radiation
__	__	Colitis
__	__	Congenital Heart Defect
__	__	Diabetes
__	__	Emphysema
__	__	Epilepsy \ Fainting Spells
__	__	Fever Blisters
__	__	Frequent Headaches
__	__	Sinus Problems
__	__	Hay Fever
__	__	Glaucoma
__	__	Heart Surgery
__	__	Heart Attack
__	__	Hemophilia
__	__	Hepatitis A\ B\ C
__	__	High Blood Pressure
__	__	HIV \ AIDS
__	__	Kidney Problems
__	__	Liver Disease
__	__	Low Blood Pressure

Y	N	Conditions
__	__	Mitral Valve Pro-lapse
__	__	Pace Maker
__	__	Psychiatric Care
__	__	Rheumatic Fever
__	__	Seizures
__	__	Stroke
__	__	Thyroid Problems
__	__	Tuberculosis
__	__	Ulcers
__	__	Venereal Disease
__	__	Yellow Jaundice
__	__	Do you smoke /use tobacco?
__	__	Do you need an antibiotic before any dental work?

Please list major surgeries:

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Women: Are you pregnant? Y N

Allergies:_____
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Medications and/or Herbal Supplements:

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