

PATIENT INFORMATION NEEDED FOR COMPUTER BILLING

Date _____

Insurance Holder _____ Date of Birth _____

Complete Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Spouse's Name _____ Date of Birth _____

Children's First and Last Names

M - F

Date of Birth

- _____

- _____

- _____

- _____

- _____

Insurance Holder Place of Employment _____

Business Phone _____

Spouse Employed by _____

Business Phone _____

INSURANCE COVERAGE

Dental _____

Address _____

Subscriber's Name _____

Social Security No. _____

Policy No. _____ Group No. _____

Remarks

WELCOME

The benefits of a healthy happy smile are immeasurable. Our goal is to help you reach and maintain oral health. Thank you for filling out this form. The better we communicate, the better we can care for you.

CONFIDENTIAL

Health History

A COMPLETE AND ACCURATE HEALTH HISTORY IS ESSENTIAL FOR PROPER DENTAL CARE.

Name: _____ Age: _____ Date of Birth: _____
 Address: _____ Social Security: _____
 City: _____ State: _____ Zip: _____ Home Phone: _____
 Email: _____ Work Phone: _____
 Cell Phone: _____

DENTAL - MEDICAL HISTORY

Reason for dental visit? _____
 When was your last dental visit? _____
 How were you referred to our office? _____
 When was your last physical exam? _____ (approx.)
 Name of family doctor _____ Phone _____
 Party to notify in case of emergency _____ Phone _____
 Address _____

PLEASE CHECK "YES" OR "NO"

Are you in good health? YES NO
 Do you use tobacco products? YES NO
 Are you currently under medical care? YES NO
 IF YES, explain: _____
 Do you take any medications regularly? YES NO
 IF YES, identify: _____
 Have you had any serious illnesses or injuries? YES NO
 IF YES: explain: _____

LADIES:
 Are you pregnant?
 YES NO
 Do you take estrogens or hormones?
 YES NO
 Do you take birth control pills?
 YES NO

DO YOU HAVE OR HAVE YOU BEEN TREATED FOR ANY OF THE FOLLOWING:

Heart Disease / Attack	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tuberculosis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Stroke	<input type="checkbox"/> YES <input type="checkbox"/> NO
Mitral Valve Prolapse	<input type="checkbox"/> YES <input type="checkbox"/> NO	Kidney Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hayfever	<input type="checkbox"/> YES <input type="checkbox"/> NO
Allergy to Penicillin	<input type="checkbox"/> YES <input type="checkbox"/> NO	Bleeding Disorder	<input type="checkbox"/> YES <input type="checkbox"/> NO	AIDS / HIV	<input type="checkbox"/> YES <input type="checkbox"/> NO
Transfusions	<input type="checkbox"/> YES <input type="checkbox"/> NO	Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Artificial Joint	<input type="checkbox"/> YES <input type="checkbox"/> NO
High/Low Blood Pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO	Jaundice	<input type="checkbox"/> YES <input type="checkbox"/> NO	Venereal Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
Breathing Difficulty	<input type="checkbox"/> YES <input type="checkbox"/> NO	Arteriosclerosis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Allergies	<input type="checkbox"/> YES <input type="checkbox"/> NO
Radiation Therapy	<input type="checkbox"/> YES <input type="checkbox"/> NO	Epilepsy	<input type="checkbox"/> YES <input type="checkbox"/> NO	Allergy to Anesthetics	<input type="checkbox"/> YES <input type="checkbox"/> NO
Tumors or Growths	<input type="checkbox"/> YES <input type="checkbox"/> NO	Dialysis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Allergy to metal	<input type="checkbox"/> YES <input type="checkbox"/> NO
Rheumatic Fever	<input type="checkbox"/> YES <input type="checkbox"/> NO	Arthritis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Allergy to latex	<input type="checkbox"/> YES <input type="checkbox"/> NO
Allergy to medications	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hepatitis	<input type="checkbox"/> YES <input type="checkbox"/> NO		

PLEASE EXPLAIN ANY "YES" ANSWERS:

IS THERE ANY OTHER MEDICAL CONDITION ABOUT WHICH WE SHOULD KNOW? YOUR MEDICAL HEALTH MAY AFFECT OUR DENTAL TREATMENT. USE THIS SPACE FOR COMMENTS:

Date _____ Patient (Parent) Signature _____ Reviewed By _____

<u>REVIEW DATE</u>	<u>CHANGE IN HEALTH STATUS</u>	<u>PATIENT'S SIGNATURE</u>	<u>REVIEWED BY</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____