

PATIENT INFORMATION FORM

We would like to take this opportunity to welcome you to our office

Who could we thank for your referral to us

APPOINTMENT FOR YOURSELF:

APPOINTMENT FOR YOUR CHILD:

Date	Social Security #	Date		
Name		Name		
Spouse		Address		
Address		City	State	ZIP
City	State	ZIP	Home Phone	
Home Phone	Work Phone	Birthdate	Age	Grade
Birthdate	Age		School	
MARRIED	SINGLE	DIVORCED	WIDOWED	

PRIMARY INSURANCE CARRIER

SECONDARY INSURANCE CARRIER

Insurance Company	Insurance Company
Employee	Employee
Union or Local #	Union or Local #
Badge #	Badge #
Date Employed	Date Employed
Social Security #	Social Security #

YOU

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

YOUR SPOUSE

Name	Birthdate	Name	Birthdate
Occupation		Occupation	
Employer		Employer	
Business Address	City	Business Address	City
Business Phone	EXT	Business Phone	EXT
S.S. No.	Drivers License	S.S. No.	Drivers License

HEALTH HISTORY

1. Have you been a patient in the hospital during the past two years? Yes No
 2. Have you been under the care of a medical doctor during the past two years? Yes No

Physician's Name _____

Address _____ Phone # _____

3. Have you taken any medicine or drugs during the past two years? Yes No
 Are you now taking any medication, drugs or pills?..... Yes No

If yes, please list: _____

4. Do you have any known allergies? Yes No

5. Are you aware of being allergic to any medications or substance?..... Yes No

If yes, please list: _____

6. Check the box for any of the following which you have had or have at present:

- | | | |
|-------------------------------|---------------------------------|--|
| Heart Failure | Emphysema | A.I.D.S |
| Heart Disease or Attack | Cough | Hepatitis A (infectious) |
| Anginea Pectoris | Tuberculosis (TB) | Hepatitis B (serum) |
| High Blood Pressure | Asthma | Liver Disease |
| Heart Murmur | Hay Fever | Yellow Jaundice |
| Mitral Valve Prolapse | Sinus Trouble | Blood Transfusion |
| Rheumatic Fever | Allergies or Hives | Drug Addiction |
| Congenital Heart Lesions | Diabetes | Hemophilia |
| Scarlet Fever | Thyroid Disease | Venereal Disease (Syphilis, Gonorrhea) |
| Artificial Heart Valve | X-ray or Cobalt Treatment | Cold Sores |
| Heart Pacemaker | Chemotherapy (Cancer, Leukemia) | Fever Blisters |
| Heart Surgery | Arthritis | Epilepsy or Seizures |
| Artificial Joints (Hip, Knee) | Rheumatism | Fainting or Dizzy Spells |
| Anemia | Cortisone Medicine | Nervousness |
| Stroke | Glaucoma | Psychiatric Treatment |
| Kidney Trouble | Pain in Jaw Joints | Sickle Cell Disease |
| Ulcers | H.I.V. | Bruise Easily |
| Cosmetic Surgery | | |

FOR WOMEN ONLY

Are you pregnant? Yes No If yes, what month? _____ Are you taking birth control pills? Yes No

ABOVE INFORMATION TRUE

Patient Signature _____ Date _____

CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with (Name of Patient) _____ and further authorize any consent that Doctor choose and employ such assistance as he deems fits. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered, unless financial arrangements have been made. I further understand that a 1.5% finance charge (18% annually) will be added to any balnce over 45 days. In the event of default, I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. I understand and agree that I am responsible for the payment of all treatment fees on your account. If my insurance compay fails to pay within 45 days, I will be responsible for the full amount.

Responisble Party _____ Date _____

Relationship to Patient _____