Confidential Patient Information – I

(Please Print Legibly)

Date: _____

Personal Information

Name: _____ SS #: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work) _____

(Cell) _____ 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 Co: _____

Insurance Co. Address: _____

Employee: _____ Relationship: _____ S.S. #: _____

Employer: _____ Policy #: _____

Secondary Insurance Co: _____

Insurance Co. Address: _____

Employee: _____ Relationship: _____ S.S. #: _____

Employer: _____ Policy #: _____

I understand that payment is my obligation regardless of insurance or any other third-party involvement.

_____ _____

PATIENT'S NAME **DATE**

Confidential Patient Information – II

(Please Print Legibly)

Patient Name: _____ Initial Date: _____

Updated: _____

Updated: _____

Updated: _____

Health Information

Personal Physician Name: _____

Personal Physician Address: _____

YES	NO	
❑	❑	1. Have you been hospitalized within the past 2 years? For what? _____
❑	❑	2. Are you currently being treated by a physician? For what? _____
❑	❑	3. Are you currently taking any medicines or drugs? What? _____
		_____
❑	❑	4. Have you ever received counseling for excessive use of alcohol and/or prescription drugs?
❑	❑	5. Are you allergic to any drugs? What? _____
❑	❑	6. Have you ever had a skin rash or other reaction to metal jewelry? To What? _____
❑	❑	7. Are you allergic to any metals? What? _____
❑	❑	8. Do you bleed excessively upon injury?
❑	❑	9. Are you pregnant?
❑	❑	10. Have you ever been involved with dental/medical legal activity?

Circle Any of the Following Conditions That You Have Had or Now Have

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. Osteoporosis
Q. Rheumatic Fever
R. Sexually Transmitted Diseases
S. Stroke
T. Tuberculosis
U. Other Diseases*

Person to Be Contacted in Case of Emergency (Other Than Relative)

Name: _____

Address: _____

Telephone: (Home) _____ (Work) _____