PATIENT INFORMATION SHEET

(Office Use)
Initial
Date

Patient Name: _____ DOB: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
E-MAIL Address: _____
Home Phone: _____ Work: _____ Cell Phone: _____
Please circle: Male Female Married Single Child Other _____
SS#: _____ (Due to data processing requirements SS# required)
Patient/Guardian:
Employer Name _____ Address: _____
Phone: _____ Occupation: _____
Doctor's name that you are seeing today: _____

Spouse Name: _____ Work Phone: _____

Guardian's name and address: _____
DOB: _____ SS# _____ Phone: _____
_____
Primary Insurance Company: _____
Address: _____
Policy Holder Name: _____
DOB: _____ SS# _____
Policy holders employer: _____
Member#: _____ Group #: _____ Effective date: _____

Secondary Insurance Company: _____
Address: _____
Policy Holder Name: _____
DOB: _____ SS# _____
Policy holders employer: _____
Member#: _____ Group #: _____ Effective date: _____
*** (If insurance is under spouse's name, please give name, DOB and SS#)***

Emergency Contact Name: _____.
(Other than spouse)
Home Phone: _____ Work: _____ext_____
Relationship to patient: _____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? Another patient/friend Another patient/relative
Dental Office Yellow Pages Newspaper School Work TV Commercial Flyer Other
Name of person or office referring you to our practice _____

HEALTH INFORMATION

HAVE YOU EVER HAD ANY OF THE FOLLOWING: PLEASE CHECK THOSE THAT APPLY:

[ ] AIDS/HIV
[ ] Anemia
[ ] Arthritis/Rheumatism
[ ] Joint Replacement
[ ] Asthma
[ ] Cancer
[ ] Diabetes
[ ] Dizziness/Fainting
[ ] Epilepsy
[ ] Excessive Bleeding
[ ] Heart Disease
[ ] Heart Murmur
[ ] Heart Attack
Date: _____

[ ] Hepatitis/Jaundice
[ ] High Blood Pressure
[ ] Kidney Disease
[ ] Liver Disease
[ ] Mental Disorders
[ ] Nervous Disorders
[ ] Pacemaker
[ ] Are You Currently Pregnant?
Due Date: _____
[ ] Radiation Treatment
[ ] Respiratory Problems
[ ] Rheumatic Fever
[ ] Sinus Problems

[ ] Stomach Problems
[ ] Stroke
Date: _____
[ ] Tuberculosis
[ ] Tumors
[ ] Venereal Disease
[ ] Cold sore
[ ] Herpes
[ ] Allergies/Seasonal
[ ] LATEX Allergy
[ ] Codeine Allergy
[ ] Penicillin Allergy
[ ] Other: _____

Please list all medications and Pharmacy: _____

_____

When was your last dental visit/cleaning: _____

Reason for this visit: _____

Have you ever had any complications following dental treatment [ ] Yes [ ] No
If yes please explain: _____

Are you now under the care of a physician: [ ] Yes [ ] No
If yes please explain: _____
Name of Physician: _____ Phone: _____

Consent For Services

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said service are rendered. I further agree that waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term of condition and I further agree to pay all costs and reasonable attorney fees of suit be instituted hereunder.

X _____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian.

Consent to File Insurance or responsible for payment

Patients who carry dental insurance understand that dental services furnished are charged directly to the patient and he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. I grant permission to this office to release any records, x-rays or personal information needed to the insurance company for payment of claims.

I grant permission to you or your assignee, to telephone me at my work to discuss matters related to this form.

I have read the conditions of treatment and payment and agree to content.

X _____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian responsible for payment.

PLEASE SIGN BOTH OF THE ABOVE LINES