Chart #: ____________

FOR OFFICE USE ONLY

Patient Information

Patient Name: ______________________________ Date: ____________

Last First MI

☐ Male ☐ Female ☐ Non Binary ☐ Married ☐ Single ☐ Child ☐ Other ____________

Social Security #: ____________________ Birth Date: ____________________

(Home/Work): ____________ (Cell): ______________ (Email): ________________

Address: ____

Street Apartment #

____

City State Zip Code

Health Information

Date of Last Dental Visit: ____________ Reason for Visit Today: ______________________

Please check those that apply:

☐ HIV

☐ Allergies ________ ________

☐ Anemia

☐ Arthritis

☐ Artificial Joints

☐ Asthma

☐ Blood Disease

☐ Cancer

☐ Diabetes

☐ Dizziness

☐ Epilepsy

☐ Excessive Bleeding

☐ Fainting

☐ Glaucoma

☐ Growths

☐ Hay Fever

☐ Head Injuries

☐ Heart Disease

☐ Heart Murmur

☐ Hepatitis

☐ High Blood Pressure

☐ Jaundice

☐ Kidney Disease

☐ Liver Disease

☐ Latex

☐ Mental Disorders

☐ Nervous Disorders

☐ Pacemaker

☐ Pregnancy

Due date: ________

☐ Radiation Treatment

☐ Respiratory Problems

☐ Rheumatic Fever

☐ Rheumatism

☐ Sinus Problems

☐ Stomach Problems

☐ Stroke

☐ Tuberculosis

☐ Tumors

☐ Ulcers

☐ Venereal Disease

☐ Codeine Allergy

☐ Penicillin Allergy

OTHER:

☐ ____________

☐ ____________

• Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain:

____

• Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain:

____

• Are you now under the care of a physician for anything other than routine checkups? ☐ Yes ☐ No
If yes, please explain:

____

• Name of Physician: ____ Phone: ____________________

• Do you have any health problems that need further clarification/? ☐ Yes ☐ No

• Are you currently taking any medications? ☐ Yes ☐ No
If yes, please list them here:

____
____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date: ____________________

Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend or relative

☐ Referring Office ☐ Google ☐ Website ☐ ZocDoc ☐ Work ☐ Other__________________

Name of person or office referring you to our practice:
____

Emergency Contact Information

Name____ Relation:

Phone (Home): _______________ (Cell): _______________ (Work)______________________________

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _________________________________ Occupation: ___________________________

Insurance Information

Primary

Name of Insured: ____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: ________________ ID #: ____________________ Group #:___________________

Insured's Address: ____

Street City State Zip Code

Insured's Employer Name: ____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other__________________

Insurance Carrier Name:____

Secondary

Name of Insured: ____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: ________________ ID #: ____________________ Group #:___________________

Insured's Address: ____

Street City State Zip Code

Insured's Employer Name: ____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_________________

Insurance Plan Name:____

Consent for Services

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employ any such assistance as he/she deems appropriate.

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

_______________________________________ Date: __________ Relationship to Patient: _______________

Signature of patient, parent or guardian

_______________________________________ Date: __________ Relationship to Patient: _______________

Signature of guarantor of payment/responsible party