PATIENT INFORMATION

NAME _____

ADDRESS _____ HOME # _____

_____ WORK # _____

SOC. SEC# _____ D.O.B. _____ CELL # _____

BUSINESS: _____

REFERRING DENTIST _____ TELEPHONE _____

PHYSICIAN _____ TELEPHONE _____

Do you or have you ever had?	Check One:		Do you or have you ever had?	Check One:	
1. Anemia	Yes ☐	No ☐	10. Allergic to penicillin	Yes ☐	No ☐
2. Diabetes	Yes ☐	No ☐	11. Other medical allergies	Yes ☐	No ☐
3. Rheumatic fever	Yes ☐	No ☐	12. Latex allergy	Yes ☐	No ☐
4. Hepatitis or any other liver disease	Yes ☐	No ☐	13. Are you a bleeder	Yes ☐	No ☐
5. T.B.	Yes ☐	No ☐	14. Do you take hormones or birth control pills	Yes ☐	No ☐
6. Thyroid disease	Yes ☐	No ☐	15. Are you pregnant	Yes ☐	No ☐
7. Kidney disease	Yes ☐	No ☐	16. Joint replacement	Yes ☐	No ☐
8. Heart disease (high blood pressure, angina, heart attack, etc.)	Yes ☐	No ☐	17. Exposure to HIV virus	Yes ☐	No ☐
9. Mitral valve prolapse	Yes ☐	No ☐	18. Exposure to COVID-19	Yes ☐	No ☐

REMARKS _____

LIST MEDICATIONS _____

* FULL PAYMENT IS EXPECTED BY COMPLETION OF TREATMENT *

Person Responsible for Account - Check one: ☐ Patient ☐ Father (Husband) ☐ Mother (Wife) ☐ Guardian

NAME _____

ADDRESS _____

PRIMARY DENTAL INSURANCE CO. _____

POLICY HOLDER NAME _____ D.O.B. _____

MEMBER ID# _____ SOC. SEC. # _____

GROUP # _____ RELATIONSHIP TO PATIENT _____

SECONDARY DENTAL INSURANCE CO. _____

POLICY HOLDER NAME _____ D.O.B. _____

MEMBER ID# _____ SOC. SEC. # _____

GROUP # _____ RELATIONSHIP TO PATIENT _____

Signature of Responsible Party _____ Date _____