

CONFIDENTIAL PATIENT INFORMATION

(Please Print Legibly)

Date _____

PERSONAL INFORMATION

Name: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work) _____

(Cell) _____ e-mail: _____

Birthdate: _____ Sex: _____ Marital Status: _____ Spouse Name: _____

Employer: _____ Referred by: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relationship: _____ SS#: _____

Address: _____ DOB: _____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work) _____

DENTAL INSURANCE INFORMATION

Primary Insurance Co. _____

Insurance Co. Address: _____

Employee: _____ Relationship: _____ SS#: _____

Employer: _____ Policy #: _____

Secondary Insurance Co. _____

Insurance Co. Address: _____

Employee: _____ Relationship: _____ SS#: _____

Employer: _____ Policy #: _____

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

SIGNATURE:	DATE:
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CONFIDENTIAL PATIENT INFORMATION II

(Please Print Legibly)

Patient Name: _____ Initial Date: _____
Update: _____
Update: _____
Update: _____
Update: _____

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 or excessive use of alcohol and/or prescription drugs?
- 5. Are you allergic to any drugs? What? _____
- 6. Are you allergic to any metals? What? _____
- 7. Have you ever had a skin rash or other reaction to metal jewelry? To what? _____
- 8. Do you bleed excessively upon injury?
- 9. Are you pregnant?
- 10. Do you snore?
- 11. Do you have morning headaches?

CIRCLE ANY OF THE FOLLOWING CONDITION THAT YOU HAVE HAD

- | | | | |
|--------------|------------------------|---|----------------------------------|
| A. AIDS | G. Glaucoma | M. Kidney Problems | P. Rheumatic Fever |
| B. Arthritis | H. Heart Murmur | N. Low Blood Pressure | Q. Sexually Transmitted Diseases |
| C. Asthma | I. Heart Problem* | O. Nervous Breakdown or Psychiatric Therapy | R. Stroke |
| D. Cancer | J. Hepatitis | | S. Tuberculosis |
| E. Diabetes | K. High Blood Pressure | | T. Other Diseases |
| F. Epilepsy | L. Jaundice | | |

PERSON TO BE CONTACTED IN CASE OF EMERGENCY

Name: _____
Address: _____
Telephone: (Home) _____ (Work) _____

SIGNATURE:	REVIEW BY:	DATE: