PATIENT INFORMATION RECORD

PATIENT INFORMATION (Please Print)

Patient's Name: _____
First MI Last

Birth Date: _____ Age: _____ Sex: _____ Nickname: _____

Home Address: _____
Street City State Zip

Home Phone ( ) _____ SS# _____ School: _____

Physician: _____ Tel # ( ) _____

Dentist: _____ Tel # ( ) _____

Patient Referred by: _____ Tel # ( ) _____

Has this office ever treated you or any member of your family? _____

Patient Name: _____ Seen by Doctor: _____

FATHER'S INFORMATION:

Name: _____

Address: _____

_____

Phone # ( ) _____

SS #: _____

Birthdate: _____

Driver's Lic. #: _____

Employer: _____

Address: _____

_____

Phone # ( ) _____ ext.: _____

Position: _____

MOTHER'S INFORMATION:

Name: _____

Address: _____

_____

Phone # ( ) _____

SS #: _____

Birthdate: _____

Driver's Lic. #: _____

Employer: _____

Address: _____

_____

Phone # ( ) _____ ext.: _____

Position: _____

DENTAL INSURANCE INFORMATION:

Company: _____

Address: _____

Phone # _____

Insured: _____

Relationship to insured: _____

Member ID#: _____

Policy #: _____

MEDICAL INSURANCE INFORMATION:

Company: _____

Address: _____

Phone # _____

Insured: _____

Relationship to insured: _____

Member ID#: _____

Policy #: _____

DENTAL INSURANCE INFORMATION:

Company: _____

Address: _____

Phone # _____

Insured: _____

Relationship to insured: _____

Member ID#: _____

Policy #: _____

MEDICAL INSURANCE INFORMATION:

Company: _____

Address: _____

Phone # _____

Insured: _____

Relationship to insured: _____

Member ID#: _____

Policy #: _____

Please Complete Reverse Side of Form

MEDICAL HISTORY

Height: _____ Weight: _____

Are you allergic or sensitive to any drugs or medications? _____

Have you ever had a reaction to local or general anesthesia? _____

Have you ever had a bleeding tendency? _____

Do you wear contact lenses? _____

Have you had anything to eat or drink within the last eight hours? _____

Are you pregnant? _____

Are you currently under the care of a physician? If so, for what? _____

Are you now or have you ever taken weight control medication? (Phen-Fen) _____

Are you currently on any medications? (High blood pressure, birth control, etc.) If so, please list with dosage and schedule:

_____

_____

SERIOUS ILLNESS (Indicate YES or NO)

	YES	NO		YES	NO
Tuberculosis (TB)	❑	❑	Thyroid problems	❑	❑
Heart attack	❑	❑	Glaucoma or eye problems	❑	❑
Heart failure	❑	❑	Sinus disease	❑	❑
Angina pectoris (chest pain)	❑	❑	Diabetes	❑	❑
Heart rhythm problem	❑	❑	Ulcer or bowel disease	❑	❑
Heart murmur	❑	❑	Epilepsy or seizure	❑	❑
Rheumatic fever	❑	❑	Kidney disease or problems	❑	❑
High blood pressure	❑	❑	History of alcohol problem	❑	❑
Artificial heart valve	❑	❑	Drug abuse problem	❑	❑
Mitral valve prolapse	❑	❑	Viral infection (i.e. AIDS or CMV)	❑	❑
Heart pacemaker	❑	❑	Prior blood transfusion	❑	❑
Artificial joint	❑	❑	Psychiatric counseling	❑	❑
Heart surgery	❑	❑	Pain or popping in jaw joints (TMJ)	❑	❑
Stroke or paralysis	❑	❑	Radiation treatment	❑	❑
Asthma or wheezing	❑	❑	Chemotherapy	❑	❑
Emphysema or lung disease	❑	❑	Hepatitis	❑	❑
Steroid treatment (i.e. Prednisone)	❑	❑	Any other medical disorder	❑	❑

SOCIAL HISTORY

Tobacco _____ packs per day. Alcohol: _____ oz. per day

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance carrier.

I acknowledge full responsibility for payment of services. This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to the doctor named on the insurance claim form otherwise payable to me.

Signed: _____ Date: _____

If Minor, Relationship to Patient: _____

Witness: _____

MEDICAL UPDATE: _____