

PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name _____
Last First MI (Preferred)

Birthdate _____ SS# _____ Gender: M F Married: Y N

Work Phone _____ Wireless Phone _____ Wireless Carrier _____

Email _____

Preferred contact method HmPhone WkPhone WirelessPh Email

Preferred contact method for confirmations HmPhone WkPhone WirelessPh Email

Preferred contact method for recall HmPhone WkPhone WirelessPh Email

Student status if dependent over 19 (for ins) Nonstudent Fulltime Parttime

How did you hear about us?

(If someone referred you here, please write down their name so we can thank them.)

ADDRESS AND HOME PHONE

Address _____

Address 2 _____

City _____ State _____ Zip _____

Home Phone _____

INSURANCE POLICY 1

Your relationship to subscriber: Self Spouse Child

Subscriber Name _____ Subscriber ID # _____

Insurance Company _____ Phone _____

Employer _____ Group Name _____ Group # _____

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your relationship to subscriber: Self Spouse Child

Subscriber Name _____ Subscriber ID # _____

Insurance Company _____ Phone _____

Employer _____ Group Name _____ Group # _____

Comments:

Medical History for New Patient

Last Name: _____ First Name: _____ Birthdate: _____
Name of Medical Doctor: _____ City/State: _____
Emergency Contact _____ Phone _____ Relationship _____

List all medications that you are now taking:

_____	_____
_____	_____
_____	_____
_____	_____

Are you allergic to any of the following?

Y	N		Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Anesthetic	<input type="checkbox"/>	<input type="checkbox"/>	Iodine
<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Latex
<input type="checkbox"/>	<input type="checkbox"/>	Codeine	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin
<input type="checkbox"/>	<input type="checkbox"/>	Ibuprofen	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa

Do you have any of the following medical conditions?

Y	N		Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Treatment
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble
<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever

Tobacco use? If so, what kind and how much? _____

Unusual reaction to dental injections? _____

Reason for today's visit _____ Are you in pain? _____

New patients: _____

Date of last cleaning and exam _____

Date: _____

Notice of Privacy Policies

Last Name:

First Name:

Birthdate:

Date:

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

X _____