NEW PATIENT INFORMATION FORM

Patient Name: _ _

Address: _ _

City: **State:** **Zip:**

Home Phone: **Work Phone:** **Cell Phone:**

Sex:«SD> **Married:** **Birth Date:** _ **Social Security:**

Employer: **Occupation:**

Spouse Information

His/Her Name:	**Birth Date:**	**Social Security:**
Employer:	**Work Phone:**	

Person Responsible for Account:	
Billing Address:(if different)	
Whom May We Thank For Referring You	**Other Family Members seen by us?**
Present/Previous Dentist:	**Last visit:**

Primary Dental Insurance

Subscriber Name:		**Relation to Patient**(self,spouse,child,other)
Social Security#:	**Birth Date:**	**Employer:**
Subscriber Address:		
Insurance Company:		**Group #:**
Address:		**Telephone:**

Secondary Dental Insurance

Subscriber Name:		**Relation to Patient**(self,spouse,child,other)
Social Security#:	**Birth Date:**	**Employer:**
Subscriber Address:		
Insurance Company:		**Group #:**
Address:		**Telephone:**

Patient Medical History

Patient's Name:	
Physician's Name:	**Pharmacy:**

Y	N	*If female, please answer the following:*
		Are you taking birth control pills?
		Are you pregnant?
		Are you nursing?

Y	N	
		Do you smoke or use tobacco?

Y	N	*Conditions*
		Hepatitis A
		Hepatitis B
		High Blood Pressure
		HIV / AIDS
		Kidney Problems
		Liver Disease
		Low Blood Pressure
		Mitral Valve Prolapse
		Pace Maker
		Pneumocystitis
		Psychiatric Problems
		Radiation Therapy
		Rheumatic Fever/ Scarlet Fever
		Seizures
		Shingles
		Sickle Cell Anemia
		Sinus Problems
		Stroke
		Thyroid Problems
		Tuberculosis
		Ulcers
		Venereal Disease
		Yellow Jaundice

Y	N	*Conditions*
		Abnormal Bleeding
		Alcohol/Drug Abuse
		Allergies
		Angina Pectoris
		Arthritis
		Artificial joints
		Artificial heart valves
		Asthma
		Blood transfusions
		Cancer-Chemotherapy
		Colitis
		Congenital Heart Defect
		Cosmetic Surgery
		Diabetes
		Difficulty breathing
		Emphysema
		Epilepsy
		Fainting Spells
		Fever Blisters
		Frequent Headaches
		Glaucoma
		Hay Fever
		Heart Attack
		Heart Murmur
		Hemophilia

Y	N	*Allergies*
		Aspirin
		Codeine
		Dental Anesthetics
		Erythromycin
		Jewelry
		Latex
		Metals
		Penicillin
		Tetracycline
Other:		

Medications:

Y	N	
		Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below
		Are you having a dental problem? Please explain.

I understand that the information given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence. I understand that even though I may have some type of dental insurance, I am responsible for payment of services not covered by my insurance coverage. Our office reserves the right to charge for broken appointments. Patient or Guardian is liable for any court costs, interest, and or collection fees for unpaid balances.

Signature: _____ Date: _____

HIPAA Acknowledgement

I have received this office's Notice of Privacy Practices. Your signature below acknowledges receipt of said Privacy Practice. If you are parent or guardian of a child of this practice, your signature acknowledges receipt for the child.

Signature: _____ Date: _____