UPDATED – Patient Information

NAME: _____ DOB: _____ S.S.#: _____

ADDRESS: _____ CITY: _____ ZIP: _____

PHONE: _____ HOW WOULD LIKE TO BE CONTACTED? TEXT / EMAIL / PHONE

RESPONSIBLE PARTY'S NAME: _____ PHONE #: _____

DOB: _____ S.S. #: _____ RELATIONSHIP to Patient: _____

ADDRESS: _____ CITY: _____ ZIP: _____

EMPLOYED BY: _____ PHONE #: _____

EMPLOYER ADDRESS: _____ PHONE: _____

NAME of DENTAL INSURANCE: _____ PHONE: _____

ADDRESS: _____ GROUP #: _____

POLICY HOLDER'S NAME: _____DOB: _____S.S.#: _____

NAME of SECONDARY INSURANCE: _____PHONE #: _____

ADDRESS: _____ GROUP #: _____

POLICY HOLDER'S NAME: _____DOB: _____S.S.#: _____

Who May We Contact in Case of an Emergency? NAME: _____

RELATIONSHIP to Patient: _____ PHONE #: _____

I HEREBY AUTHORIZE payment directly to the doctor of benefits due me for his services as described. I understand I am financially responsible for charges not covered by this authorization. I also authorize the release of any medical information relating to this claim, and if my account should become delinquent of more than 90 days an interest fee of 1% per month will incur to my account.

Patient, Insured, or Guardian Signature: _____

Date: _____

MEDICAL HISTORY

1. Have you been a patient in a hospital during the past 3 years? YES NO

   If yes, Reason: _____

2. Are you now or have you been under the care of a physician during the past 3 years? YES NO

   If yes, Reason: _____

   Physician's Name_____Phone_____

3. Have you taken any kind of medicine or drugs during the past year? YES NO

   Please List: _____

4. Allergic to any drugs or medications? YES NO

   Please List: _____

5. Have you ever had excessive bleeding requiring special treatment? YES NO

   If yes, Reason: _____

6. Have you ever had? (Please circle what applies to you.)

Heart Trouble	High Blood Pressure	Rheumatic Fever	Heart Murmur
Joint Replacement	Asthma	Cough	Tuberculosis
Diabetes	Hepatitis	Jaundice	Aids
Arthritis	Stroke	Epilepsy	Psychiatric Treatment

7. Have you ever had any other serious illness? YES NO

   Please list: _____

8. Do you use cocaine or any recreational drugs? YES NO

   Please list: _____

9. (Women) Are you pregnant now? YES NO

10. (Women) Are you undergoing menopause now? YES NO

Patient Signature or Guardian: _____ Date: _____