

**NEW PATIENT INFORMATION FORM**

NAME (Last, First, Middle): \_\_\_\_\_ TITLE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PREFERRED NAME: \_\_\_\_\_ SS NO: - - DOB: / /

HOME PHONE: \_\_\_\_\_ MARITAL: S/M/D/W REF. DOCTOR: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ SEX: M / F REF. PATIENT: \_\_\_\_\_

EMAIL: \_\_\_\_\_

**MEDICAL ALERTS:** \_\_\_\_\_

**PRIMARY DENTAL INSURANCE COVERAGE**

SUBSCRIBER NAME: \_\_\_\_\_ RELATION TO PATIENT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SS NO: - - EMPLOYER: \_\_\_\_\_

DOB: / / ADDRESS : \_\_\_\_\_

PLAN NAME: \_\_\_\_\_ GROUP NO: \_\_\_\_\_ IND YRLY DEDUCT: \_\_\_\_\_

INSURANCE CO: \_\_\_\_\_ FAM YRLY DEDUCT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

**SECONDARY DENTAL INSURANCE COVERAGE**

SUBSCRIBER NAME: \_\_\_\_\_ RELATION TO PATIENT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SS NO: - - EMPLOYER: \_\_\_\_\_

DOB: / / ADDRESS : \_\_\_\_\_

PLAN NAME: \_\_\_\_\_ GROUP NO: \_\_\_\_\_ IND YRLY DEDUCT: \_\_\_\_\_

INSURANCE CO: \_\_\_\_\_ FAM YRLY DEDUCT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

**MEDICAL INSURANCE COVERAGE**

SUBSCRIBER NAME: \_\_\_\_\_ RELATION TO PATIENT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PLAN NAME: \_\_\_\_\_ GROUP NO: \_\_\_\_\_

**RESPONSIBLE PARTY**

NAME AND ADDRESS: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

# PATIENT MEDICAL HISTORY

**Patient's Name:**

**For Office Use Only**

ID:

**Address:**  **Today's Date:**  **Date of Last Visit:**  **Date of Med. History:**

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

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**Home Phone:**  **Work Phone:**  **Birth Date:**  **Social Security No.:**  **Marital Status:**

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**Primary Dental Guarantor:**  **Home Phone:**  **Work Phone:**

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**Secondary Dental Guarantor:**  **Home Phone:**  **Work Phone:**

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**Physician Name:**  **Physician Phone:**

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**Pharmacy:**  **Pharmacy Phone:**

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**For Office Use Only**

**Medical Alerts:**

**Sex:**

Unknown

**If female please answer the following:**

Y N  
  Are you taking Birth Control Pills?  
  Are you pregnant? If Yes, # of weeks   
  Are you nursing?

**Please answer the following:**

Y N  
  Do you smoke or use tobacco?  
**For Office Use Only**  
 BP  /  Heart Rate:   
 Height:   
 Weight:

Y N <u>Conditions</u>	Y N <u>Conditions</u>	Y N <u>Conditions</u>
<input type="checkbox"/> <input type="checkbox"/> Abnormal Bleeding	<input type="checkbox"/> <input type="checkbox"/> Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Stroke
<input type="checkbox"/> <input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> <input type="checkbox"/> Hay Fever	<input type="checkbox"/> <input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> <input type="checkbox"/> Allergies	<input type="checkbox"/> <input type="checkbox"/> Heart Attack	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Heart Surgery	<input type="checkbox"/> <input type="checkbox"/> Ulcers
<input type="checkbox"/> <input type="checkbox"/> Angina Pectoris	<input type="checkbox"/> <input type="checkbox"/> Hemophilia	<input type="checkbox"/> <input type="checkbox"/> Venereal Disease
<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Hepatitis A	<input type="checkbox"/> <input type="checkbox"/> Yellow Jaundice
<input type="checkbox"/> <input type="checkbox"/> Artificial Bones	<input type="checkbox"/> <input type="checkbox"/> Hepatitis B	
<input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> HIV+ AIDS	
<input type="checkbox"/> <input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> <input type="checkbox"/> Kidney Problems	
<input type="checkbox"/> <input type="checkbox"/> Cancer- Chemotherapy	<input type="checkbox"/> <input type="checkbox"/> Liver Disease	
<input type="checkbox"/> <input type="checkbox"/> Colitis	<input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure	
<input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect	<input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse	
<input type="checkbox"/> <input type="checkbox"/> Cosmetic Surgery	<input type="checkbox"/> <input type="checkbox"/> Pace Maker	
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Pneumocystitis	
<input type="checkbox"/> <input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> <input type="checkbox"/> Psychiatric Problems	
<input type="checkbox"/> <input type="checkbox"/> Drug Abuse	<input type="checkbox"/> <input type="checkbox"/> Radiation Therapy	
<input type="checkbox"/> <input type="checkbox"/> Emphysema	<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever	
<input type="checkbox"/> <input type="checkbox"/> Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Seizures	
<input type="checkbox"/> <input type="checkbox"/> Fainting Spells	<input type="checkbox"/> <input type="checkbox"/> Shingles	
<input type="checkbox"/> <input type="checkbox"/> Fever Blisters	<input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease	
<input type="checkbox"/> <input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> <input type="checkbox"/> Sinus Problems	

**Y N Allergies**

Aspirin

Codeine

Dental Anesthetics

Erythromycin

Jewelry

Latex

Metals

Penicillin

Tetracycline

**Other**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medications:**

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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...

**Notes:**

**Signature:** \_\_\_\_\_  
(If Under 18, Parent or Guardian Signature Required)

**Date:** \_\_\_\_\_