Dental Patient Information Form

Name_____Sex:___M ___F

Home phone_____ work phone_____ cell phone_____

Email address_____

Home address_____City_____Zip Code_____

Social security#_____ date of birth: _____

Drivers license number: _____ State _____Exp. Date_____

Employer Information

Employer name and address_____

Employers' phone: _____

Spouse's name: _____ work phone: _____

Nearest relative **not** living with you: _____ Phone_____

Primary care or referring physician: _____ Phone _____

Previous dentist _____ Phone_____

Whom may we contact in case of emergency? _____Phone _____

Whom may we thank for referring you? _____

Who is responsible for this bill? _____

Insurance Information

Name of insured _____ relationship to patient _____

Birth date: _____ social security number _____

Name of employer _____ office phone _____

Insurance company _____ Group# _____

Insurance company address _____city/state _____ zip _____

If this claim is accident related, please provide details of the accident

_____

Did you sustain an injury at work/school? _____

Are you covered under an employer or union policy? _____

Medical History: Do you have or have had any of the following (please circle)

AIDS

Anemia

Arthritis/Rheumatism

Artificial Heart Valves

Artificial Joints

Asthma

Back problems

Bleeding abnormalities

Blood disease

Cancer

Chemical dependency

Chemotherapy

Circulatory problems

Congenital Heart Lesions

Cortisone treatments

Cold sores/fever blister

Diabetes

Emphysema

Epilepsy

Fainting

Glaucoma

Headaches

Heart murmur

Heart attack

Heart problems

Hemophilia

Hepatitis A B C

High blood pressure

HIV

Kidney disease

Liver disease

Low blood pressure

Leukemia

Lupus

Mitral valve prolapsed

Pacemaker

Psychiatric Care/problems

Radiation treatment

Respiratory disease

Rheumatic fever

Shortness of breath

Skin rash

Sinus problems

Stroke

Thyroid problems

Tobacco habit

Positive tuberculosis

Ulcers

Vertigo

Anxiety/Depression

_____ none

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? _____

Are you allergic to any of the following?

Aspirin Penicillin Codeine Latex Acrylic Metal Local anesthetics Sulfa drugs

Are there any health conditions you have that are not listed?

If so please explain: _____

Please list all medications you are currently taking: _____

_____

Date of last dental exam _____

Reason for today's visit _____

WOMEN ONLY:

Are you pregnant? _____yes _____no due date _____

Nursing? _____yes _____no

Had an exposure to HPV? ____yes _____ no

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or in the above information. **This information will be kept confidential.**

_____ _____

Signature **Date**

Thank you and welcome to our office

Dr. Krawczyk and staff