ADULT NEW PATIENT INFORMATION FORM

NAME: _____ TODAYS DATE: _____

HOME ADDRESS: _____ ZIP _____

HOME PHONE _____ SS NO: _____ BIRTHDATE: _____ SEX M / F

WORK PHONE: _____ MARITAL: S/M/D/W REFERRED BY: _____

EMPLOYER: _____ EMPLOYER ADDRESS: _____

CELL PHONE: _____

SPOUSE INFORMATION

HIS/HER NAME: _____ BIRTHDATE: _____

ADDRESS: _____

EMPLOYER: _____ WORK PHONE: _____

PRIMARY INSURANCE INFORMATION

SUBSCRIBER NAME: _____ RELATION TO PATIENT: _____

ADDRESS: _____

SS NO: _____ EMPLOYER: _____

BIRTHDATE: _____ ADDRESS: _____

I.D.#: _____ GROUP NO: _____

INSURANCE CO: _____ ADDRESS: _____

SECONDARY INSURANCE INFORMATION

SUBSCRIBER NAME: _____ RELATION TO PATIENT: _____

ADDRESS: _____

SS NO: _____ EMPLOYER _____

BIRTHDATE: _____ ADDRESS: _____

PLAN NAME: _____ GROUP NO: _____

INSURANCE CO: _____ ADDRESS: _____

RESPONSIBLE PARTY:
SIGNATURE: _____

CONFIDENTIAL MEDICAL-DENTAL HISTORY FORM - Please indicate corrections.

LAST NAME: _____ MIDDLE: _____ FIRST NAME: _____

PHYSICIANS NAME: _____ ADDRESS: _____

MEDICAL ALERTS: _____

MEDICAL HISTORY:

Date of Last Physical Exam: _____

Are you now or have you recently been under a physician's care? __YES __NO

Reason: _____

Have you ever been a patient in a hospital or had any serious illness?

Explain: _____

Check any of the following that you have had or suspected:

YES	NO		YES	NO		YES	NO	
__	__	Arthritis	__	__	Hepatitis or Jaundice	__	__	Prolonged Bleeding
__	__	Rheumatic Fever	__	__	Liver Disease	__	__	Fainting Tendency
__	__	Heart Trouble	__	__	Cancer or Tumor	__	__	Epilepsy
__	__	Heart Murmur	__	__	Tuberculosis	__	__	Thyroid Disease
__	__	High/Low Blood Pressure	__	__	Diabetes	__	__	Glaucoma
__	__	Chest Pain	__	__	Kidney/Bladder Trouble	__	__	Radiation Treatment
__	__	Stroke	__	__	Anemia	__	__	Mental Disorders
__	__	Shortness of Breath	__	__	Lung Disease	__	__	HIV or AIDS
__	__	Asthma or Hay Fever	__	__	Venereal Disease	__	__	Prosthetic Joint Replacement
__	__	Sinus Trouble	__	__	Blood Disease	__	__	Blood Transfusion

Check any of the following that you are taking or have taken:

__ Cortisone Drugs	__ Anticoagulants	__ Tranquilizers
__ Steroids	__ Blood Thinners	__ Sedatives

Are you taking any other medication? ___YES ___NO If yes, explain:

_____

Are you allergic to or do you suffer ill effects from any of the following?

__ Penicillin	__ Codeine	__ Dental Anesthesia
__ Aspirin	__ Household Bleach	__ Other: _____

Women Only: Are you pregnant? ___YES ___NO

If yes: How many months? ___ Are you breast feeding? ___

Are you presently taking medicine of any kind routinely?

(Birth control pills, shots, or implant, hormone therapy, etc.)

Explain: _____

The above information is true to the best of my knowledge.

Signature: _____

The undersigned, hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit my claims for benefits, for services rendered or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigne had personally signed the particular claim.

Signature: _____