Chart#: _____ FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

Gender(M/F): ___ Marital Status: _____ Birth Date: _____ Social Security #: _____

Driver's License #: _____ E-Mail Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Phone #'s: Home _____ Work _____ Ext _____ Best time to call: _____

FAX _____ Pager _____ Other _____

Referral Information

Name of person, office or other source referring you to our practice:

_____

Spouse or Responsible Party Information

Name: _____ Date: _____
Last First MI (Preferred Name)

Gender(M/F): ___ Marital Status: _____ Birth Date: _____ Social Security #: _____

Driver's License #: _____ E-Mail Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Phone #'s: Home _____ Work _____ Ext _____ Best time to call: _____

FAX _____ Pager _____ Other _____

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____

Address: _____
Street City State Zip Code Phone

Insurance Information

Primary
Name of Insured: _____
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name and Address: _____

_____

Secondary
Name of Insured: _____
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name and Address: _____

_____

Other Information

Date of Last Dental Visit: _____

Have you been hospitalized in the past 2 years? _____

Are you allergic to penicillin or any other drugs? _____

Have you ever had any excessive bleeding? _____

Do you have a heart condition or Murmur? If yes please explain. _____

Do you have a cardiac pacemaker? _____

Do you have high blood pressure? _____

Do you have any artificial valves or joint replacements? _____

Have you ever had rheumatic fever? _____

Do you have diabetes? _____

Do you have epilepsy? _____

Have you ever had tuberculosis? _____

Have you ever had hepatitis? _____

Do you have HIV/AIDS? _____

Are you pregnant now? _____

Do you have any other medical conditions? If yes, what? _____

Pharmacy name and List of drugs taking currently _____

In Case Of Emergency, Notify: (Name and Phone #) _____

Do you agree with the HIPAA Privacy Practices and policies? _____

(You may request a copy of our Privacy Notice at any time.)

May we contact you at your work number if needed? _____

Signature _____ and Date:_____

_____

_____