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: ______________________________________

____

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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:__________

____