horseshoebaydental

PATIENT INFORMATION

NAME: _____ OCCUPATION: _____

ADDRESS: _____ MALE___ FEMALE___

CITY: _____ STATE: _____ ZIP: _____ PHONE: _____ CELL: _____

EMPLOYER: _____ WORK NUMBER: _____

DOB: _____ SSN: _____ EMAIL: _____

SPOUSE'S NAME: _____

RESPONSIBLE PARTY (IF DIFFERENT FROM THE PATIENT)

NAME: _____ ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ PHONE: _____ CELL: _____ DOB: _____

SSN: _____ RELATIONSHIP: _____

SOME OF OUR SERVICES MAY BE COVERED BY YOUR MEDICAL INSURANCE

MEDICAL INSURANCE:

INSURANCE COMPANY NAME: _____ POLICY NUMBER: _____

GROUP NUMBER: _____ SUBSCRIBER NAME: _____

RELATIONSHIP TO THE PATIENT: _____ DOB: _____ SSN: _____

DENTAL INSURANCE:

INSURANCE COMPANY NAME: _____ POLICY NUMBER: _____

GROUP NUMBER: _____ SUBSCRIBER NAME: _____

RELATIONSHIP TO THE PATIENT: _____ DOB: _____ SSN: _____

DO YOU HAVE SECONDARY INSURANCE? YES___ NO___

RATE THE FOLLOWING IN ORDER OF IMPORTANCE TO YOU, FROM 1-4 (1=LOWEST 4=HIGHTEST)

_____ ESTHETICS _____ FUNCTION _____ LONGEVITY _____ COMFORT

WHAT IS MOST IMPORTANT TO YOU IN A DENTIST, DENTAL TEAM, AND ORAL HEALTH?

_____

_____

_____

I AUTHORIZE THE DENTIST TO PERFORM DIAGNOSTIC PROCEDURES AND TREATMENT AS MAY BE NECESSARY FOR PROPER DENTAL CARE. I ALSO AUTHORIZE THE RELEASE OF ANY INFORMATION CONCERNING MY (OR MY CHILD'S) HEALTH CARE, MEDICAL HISTORY, ADVICE AND TREATMENT TO ANOTHER DENTIST IF APPLICABLE OR AN INSURANCE COMPANY. SINCE APPOINTMENTS ARE RESERVED EXCLUSIVELY FOR ME, I UNDERSTAND THAT CHARGES WILL OCCUR IF I GIVE LESS THAN 48 HOURS NOTICE OF AN APPOINTMENT CHANGE OR CANCELLATION.

SIGNITURE: _____ DATE: _____

LIST ALL MEDICATIONS YOU ARE TAKING:

MEDICATION NAME	DOSAGE/ FREQ.	PRESCRIBER	REASON

ARE YOU TAKING ANY BLOOD THINNERS? ☐ YES ☐ NO

HAVE YOU EVER HAD OR HAVE ANY OF THE FOLLOWING? PLEASE CHECK THOSE THAT APPLY:

___ AIDS
___ALLERGIES
TYPE?
___ANEMIA
___ARTHRITIS
___ARTIFICIAL JOINTS
___ASTHMA
___BLOOD DISEASE
___CANCER
TYPE?
___DIABETES
TYPE?
___DIZZINESS
___EPILEPSY
___EXCESSIVE BLEEDING
WHY?
___FAINTING
___GLAUCOMA
___GUM DISEASE
___HEADACHE OR MIGRAINE
___HAY FEVER
___HEAD INJURIES
___HEART DISEASE
___HEART MURMUR
___HEPATITIS
TYPE?
___HIGH BLOOD PRESSURE
___LUNG DISEASE
___KIDNEY DISEASE
___LIVER DISEASE
___MENTAL DISORDERS
___NEUROLOGICAL DISORDERS
___ORAL CANCER OR LESIONS
___PACEMAKER
___PREGNANCY (PRESENTLY)
DUE DATE:
___RADIATION TREATMENT
WHEN?
___RESPIRATORY PROBLEMS
___RHEUMATIC FEVER
___RHEUMATISM
___SINUS PROBLEMS
___STOMACH PROBLEMS
___STROKE
___THYROID PROBLEMS
___TUBERCULOSIS
___TUMORS
___ULCERS
___VENEREAL DISEASE
___CODEINE ALLERGY
___PENICILLIN ALLERGY

PLEASE LIST ANY OTHER DRUG ALLERGIES

_____
_____
_____
_____
_____

PLEASE LIST ANY OTHER MEDICAL HISTORY THAT IS NOT LISTED HERE:

_____
_____
_____
_____
_____
_____
_____

HAVE YOU BEEN ADMITTED TO A HOSPITAL OR NEEDED EMERGENCY CARE DURING THE PAST TWO YEARS?

IF YES, PLEASE EXPLAIN: _____

NAME OF PHYSICIAN:_____ PHONE:_____

PATIENT NAME:_____ DOB: _____

PATIENT SIGNATURE:_____ DATE:_____