

PATIENT INFORMATION

Patient Information:

Last Name _____ First Name _____ MI _____ DOB _____ Age _____
Address _____ City _____ State _____ Zip _____
Telephone (home) () _____ Alternate () _____ Social Security No. _____
Employer _____ Telephone () _____ () Male () Female
Address _____ City _____ State _____ Zip _____

Parent or Guardian Information:

Last Name _____ First Name _____ MI _____ DOB _____
Address _____ City _____ State _____ Zip _____
Telephone (home) () _____ Alternate () _____
Employer _____ Telephone () _____
Address _____ City _____ State _____ Zip _____
Social Security Number _____
Who is responsible for this account _____

Insurance Information:

Dental Insurance Carrier _____ Medical Insurance Carrier _____
Subscriber Name _____
Group # _____ ID # _____

Medical History

Have you had any of the following:

<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Circulatory Problems
<input type="checkbox"/> Nervous Problems	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Artificial Heart Valves	<input type="checkbox"/> Back Problems
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Hepatitis, Liver Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Allergies to Medicines
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> AIDS/HIV
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Hemophilia

Do you have any drug allergies or adverse reaction to any medication? _____

Are you taking any medication at this time? _____ If so, what _____

Is there anything else we should know about your medical history? _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled.

Signature

Date