PATIENT INFORMATION MINOR

Dr.'s Initials_____

Welcome.....

Name_____Birthdate_____

Address_____Zip Code_____

Phone #(___)_____School_____

Father's name_____Occupation_____

Mother's name_____Occupation_____

Please list parent's address if different from above

_____

Previous dentist_____

Referred by_____

If there is dental coverage under which parent?_____

Insurance company_____Group #_____

Social Security#_____Birthdate_____

Employer name_____Wk #( )_____

Employer's address_____Zip_____

Please present insurance card if available.

Complete only if there is a second dental insurance carrier.

Please list name and address of second insurance carrier.

_____

Name of insured_____

Birthdate_____Social Security#_____

Employer name_____

HEALTH HISTORY

Please answer (y)yes or (n)no:

Heart Ailment	_____	Diabetes	_____
Rheumatic fever	_____	Epilepsy	_____
Heart murmur or mitral valve prolapse	_____	Respiratory disease/TB	_____
		Prolonged bleeding	_____
Heart valve replacement	_____	Hepatitis	_____
Prosthetic joint replacement	_____	AIDS or HIV +	_____
		Allergy to any drugs	_____
High/Low blood pressure	_____	Nervous/Mental Problem	_____
Cancer	_____	General Allergies	_____

Please explain any "YES" answers_____

_____

List medications taken regularly_____

Has your physician recommended that you take antibiotics prior to dental procedures?_____

The above information is accurate and complete to the best of my knowledge. I authorize this office to release any information necessary to process insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage. Please be advised of our firm policy of no less than 24 hours notice when cancelling an appointment. There will be a charge for broken appointments.

Date_____Signature_____