Patient Information

(CONFIDENTIAL)

Today's Date: _____

Name: _____ SSN: _____-_____-_____ Birthdate: _____/_____/_____

Address: _____City: _____ State: _____ Zip: _____

Primary Phone #: _____ Secondary/Work Phone #: _____ Sex: ☐M ☐F

Employer: _____Occupation: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Are you: ☐Single ☐Married ☐ Divorced ☐Widowed ☐Separated

Spouse Name: _____Spouse Employer: _____

Work Phone #:_____ Spouse DOB: ____/_____/_____ Spouse SSN: _____-_____-_____

Emergency Contact Person: _____ Phone #: _____

Responsible Party

(Complete if other than yourself)

Name of Person Responsible for this Account: _____ Relationship to Patient: _____

Address (if different from above): _____City: _____ State: _____ Zip: _____

Birthdate: ___/____/____ SSN: _____-_____-_____ Phone #: _____ Employer: _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐YES ☐NO

Insurance Information

Name of Insured: _____ Relationship to Patient: _____

Employer/Union or Local #: _____ Work Phone #: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Policy/ID #: _____ Group #:_____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ YES ☐NO If Yes, please complete the following:

Name of Insured: _____ Relationship to Patient: _____

Employer/Union or Local #: _____ Work Phone #: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Policy/ID #: _____ Group #:_____

Please complete back side of this form

Patient Medical History

Medical Physician: _____Date of Last Medical Exam: _____

Date of Last Dental Exam: _____

		YES	NO
1.	Are you under medical treatment now?	☐	☐
2.	Have you been hospitalized for any surgical operations or serious illnesses within the last 5 years?	☐	☐
	a. If yes, please explain: _____		
3.	Are you taking any medication(s) including non-prescriptions medicine?	☐	☐
	a. If yes, please list: _____		
	_____		
4.	Do you use tobacco?	☐	☐

5. Women Only:

	YES	NO
Are you pregnant or think you may be pregnant?	___	___
Are you nursing?	___	___
Are you taking oral contraceptives?	___	___

6. Are you allergic to or have you had any reactions to any of the following?

	YES	NO		YES	NO
Local Anesthetics (e.g. Novocain)	___	___	Sedatives	___	___
Penicillin or any other Antibiotics	___	___	Aspirin	___	___
Sulfa Drugs	___	___	Latex Rubber	___	___
Barbiturates	___	___	Other (please list) _____		

7. Do you have or have you had any of the following?

YES	NO		YES	NO		YES	NO	
___	___	AIDS	___	___	Hay Fever/Allergies	___	___	Low Blood Pressure
___	___	Anemia	___	___	Heart Attack	___	___	Mitral Valve Prolapse
___	___	Angina/ Chest Pain	___	___	Heart Murmur	___	___	Radiation Therapy
___	___	Asthma	___	___	Heart Trouble	___	___	Respiratory Problems
___	___	Cancer	___	___	Hepatitis/Jaundice	___	___	Rheumatic Fever
___	___	Cardiac Pacemaker	___	___	High Blood Pressure	___	___	Thyroid Problems
___	___	Diabetes	___	___	HIV Infection	___	___	Other_____
___	___	Emphysema	___	___	Joint Replacement/Implant			
___	___	Epilepsy/Convulsion	___	___	Kidney Diseases			
___	___	Fainting/Seizures	___	___	Liver Disease			

Authorization & Release

I have answered the questions on this form accurately, to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services that I may need.

I also authorize the dental staff to release any information including diagnosis and the records of treatment or examination rendered during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to Linton Family Dentistry. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. **I understand that if I default on payment for services rendered (present or future) that I will be responsible for any attorney's fees, collection fees of 40% and court costs.**

_____ _____

Signature of Patient (or parent/guardian if minor) Date