DRIGGERS & BAKER FAMILY DENTISTRY

PATIENT INFORMATION FORM

Today's Date:			Preferred Dentist:		
PATIENT INFORMATION					
Last Name: First:		Middle:	Marital status:		
Email:	Preferred Method Of Contact	Former name:	Birth date:	Age:	Sex: ○ M ○ F
Address: [Address/ P.O Box, City, ST ZIP Code]					
Social Security no.:	Home phone no.:		Cell phone no.:		
Occupation:	Employer:		Employer phone no.:		
Who may we thank for your referral today?					
Other family members seen here:					

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here?	○ Yes ○ No	Is this patient covered by insurance?	○ Yes ○ No
Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:
Patient's relationship to subscriber:					

FINANCIAL RESPONSIBILITY

Payment is due when services are performed. If you have a PPO Dental Insurance, as a courtesy, we will file a claim on your behalf. Please keep in mind that your insurance is a contract between you and your carrier. We only have the ability to estimate what insurance will pay. If payment is denied you are responsible for the entire cost of the treatment.

X_____ Date:_____

HIPPA

I acknowledge that I have read and understand the Privacy Act Notice provided to me. I authorize DRIGGERS AND ROBERTS FAMILY DENTISTRY or my insurance company to release any information required to process my claims. I understand that DRIGGERS AND ROBERTS FAMILY DENTISTRY will not share my information without my written consent.

X_____ Date:_____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Other phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance.

Patient/Guardian signature

Date

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or any medications you may be taking, could have an important interrelationship with any dental treatment you may receive. So please read carefully and thank you for answering the following questions.

Are you under a physician's care? YES NO (if yes, explain)_____

Have you been hospitalized or had an operation? YES NO (if yes, explain)_____

Have you ever had a serious head or neck injury? YES NO (if yes, explain)_____

Are you taking any medications, pills or drugs? YES NO (if yes, please list)_____

Do you take, or have you taken Phen-Fen or Redux? YES NO _____

Do you use controlled substances? YES NO

_____

Do you use tobacco? YES NO

_____

Are you on a special diet? YES NO _____

WOMEN:

Are you pregnant/trying to get pregnant? YES NO Taking oral contraceptives? YES NO Nursing? YES NO

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetic

Other (please explain)_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

AIDS/HIV	CORTISONE MEDICATION	HEMOPHILIA	RENAL DIALYSIS
ALZHEIMER'S DISEASE	DIABETES	HEPATITIS A	PHEUMATIC FEVER
ANAPHYLAXIS	DRUG ADDICTION	HEPATITIS B OR C	RHEUMATISM
ANEMIA	EASILY WINDED	HERPES	SCARLET FEVER
ANGINA	EMPHYSEMA	HIGH BLOOD PRESSURE	SHINGLES
ARTHRITIS/GOUT	EPILEPSY OR SEIZURES	HIVES OR RASH	SICKLE CELL DISEASE
ARTIFICIAL HEART VAVLE	EXCESSIVE BLEEDING	HYPOGLYCEMIA	SINUS TROUBLE
ARTIFICIAL JOINT	EXCESSIVE THIRST	IRREGULAR HEARTBEAT	SPINA BIFIDA
ASTHMA	FAINTING SPELLS/DIZZINESS	KIDNEY PROBLEMS	STOMACH/INTESTINAL DISEASE
BLOOD DISEASE	FREQUENT COUGH	LEUKEMIA	STROKE
BLOOD TRANSFUSION	FREQUENT DIARRHEA	LIVER DISEASE	SWELLING OF LIMBS
BREATHING PROBLEM	FREQUENT HEADACHES	LOW BLOOD PRESSURE	THYROID DISEASE
BRUISE EASILY	GENITAL HERPES	LUNG DISEASE	TONSILITIS
CANCER	GLAUCOMA	MITRAL VALVE PROLAPSE	TUBERCULOSIS
CHEMOTHERAPY	HAY FEVER	PAIN IN JAW JOINTS	TUMORS OR GROWTHS
CHEST PAINS	HEART ATTACK/FAILURE	PARATHYROID DISEASE	ULCERS
COLD SORES/FEVER BLISTERS	HEART MURMUR	PSYCHIATRIC CARE	VENEREAL DISEASE
CONGENITAL HEART DISORDER	HEART PACE MAKER	RADIATION TREATMENTS	YELLOW JAUNDICE
CONVULSIONS	HEART TROUBLE/DISEASE	RECENT WEIGHT LOSS	

Have you ever had any serious illness not listed above? YES NO (if yes, please explain) _____

_____.

To the best of my knowledge, the above questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the doctor and/or staff member of any changes in my (or patients) medical status.

SIGNATURE_____ **DATE**_____