PATIENT INFORMATION

Name ____ **Nickname** ______________ **Birthday** _____/_____/_____ **SS#** _____-_____-_____

Spouse's/Partner's Name ___________________________________ **Parent's Name** (child) _______________________________________

Single ❑ **Divorced** ❑ **Married** ❑ **Widowed** ❑ **Referred By** ____

Address _______________________________________ **Apt** _____ **Home #** ____

City ____________________ **State** _______ **Zip** _______________ **Cell #** ____

Address Changes ____ **Work #** ____

____ *Changes #* ____

Address Changes ____ **Employer** ____

____ **Occupation** ____

Emergency contact (not living w/ you) ____________________________ **Relationship** ______________________ **Phone #** ______________

Person Responsible for Billing (if different from patient) ____ **Relationship** ______________

Address ____ **Apt** _____ **City** _________________ **State** _______ **Zip** ____________

Home # ___________________________ **Cell #** ____________________________ **Work #** ____________________________ **Ext** _____

Dental Insurance Information

Primary Insurance Effective Date _______________

Subscriber ____

Birthday _____/_____/_____ SS#___________________________

Address ____

City _______________________ State _______ Zip ____________

Home # ____________________ Cell # ______________________

Work # ____________________ Employer ___________________

Insurance Company _____________________________________

Phone # ____

Group # _____________ ID# _______________________________

Secondary Insurance Effective Date _______________

Subscriber ____

Birthday _____/_____/_____ SS#___________________________

Address ____

City _______________________ State _______ Zip ____________

Home # ____________________ Cell # ______________________

Work # ____________________ Employer ___________________

Insurance Company _____________________________________

Phone # ____

Group # _______________ ID# ______________________________

Insurance Changes: **Subscriber** _________________________________ **Birthday** _____/_____/_____ **SS#** ________-_________-_________

Address ____**City** ___________ **State** __________ **Zip** _________

Home # _____________________ **Cell #** _______________________ **Work #** _____________________ **Employer** ____________________

Effective Date ___________ **Insurance Company** ____ **Phone #** ___________________

Group # ___________ **ID #** ________________

"I authorize release of any information relating to the dental treatment for myself and my dependents. I understand that I am responsible for all costs of dental treatment. I understand that the staff at Kent Family Dental Center will assist me in filing insurance claims, but that determining eligibility, coverage maximums and contract year are solely my responsibility. I hereby authorize payment directly to the attending dentist of the group insurance benefits otherwise payable to me."

Signed ____ Today's Date ___________________________

Health History

Name ______________________________ Birthday _____/_____/_____ SS# _____-_____-_____

Have you had any of the following:

	Yes	No		Yes	No		Yes	No
Artificial Joint	❑	❑	Herpes/Cold Sores	❑	❑	Allergies	❑	❑
Asthma	❑	❑	High Blood Pressure	❑	❑	Aspirin allergy	❑	❑
Blood Disorders	❑	❑	HIV/AIDS	❑	❑	Codeine allergy	❑	❑
Cancer	❑	❑	Implants	❑	❑	Novocain allergy	❑	❑
Diabetes	❑	❑	Kidney Disease	❑	❑	Penicillin allergy	❑	❑
Epilepsy	❑	❑	Rheumatic Fever	❑	❑	Other drug allergy ____________		
Heart Disorder	❑	❑	Tuberculosis	❑	❑			
Heart Murmur	❑	❑	Venereal Disease	❑	❑			
Hepatitis	❑	❑	Other ______________					

Are you being treated by a physician now? ________ **For what?** ______________________________

Who is your physician? ______________________________ Phone # ____________________

What medications do you take? ______________________________

Do you require premedication with antibiotics prior to dental treatment due to heart disease, implant, etc.? ____________________

Reason for dental visit ______________________________ **Date of last dental exam and x-rays** ____________

Who was your former dentist? ______________________________ Phone # ____________________

Updated Information

Date __________ Changes ______________________________ Initial _______

Date __________ Changes ______________________________ Initial _______

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