Today's Date_____

DeForest DENTAL SERVICES

Patient Information

Patient Name _____
Last First Middle

I Prefer to Be Addressed as _____

Date of Birth_____ Age_____

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Patient Address _____

City_____ State_____ Zip Code _____

Social Security #_____ Sex ❑ M ❑ F

Driver's Lic. #_____ Cell Phone _____

Home Phone _____ Work Phone _____

Can we reach you at your work number? ❑ Yes ❑ No

Employer _____

Occupation _____

E-mail Address* _____

For confirmation of appointments and company information only. We take your privacy very seriously.

Emergency Contact Person _____

Relationship_____

Home Phone _____ Work Phone _____

Account Information

Person Responsible for the Account

Name _____

Relation to Patient _____

Billing Address _____

City_____ State_____ Zip Code _____

Social Security #_____ D.O.B. _____

Home Phone _____ Work Phone _____

Medical Insurance Information

Medical Insurance

Insurance Company _____

Subscriber Name _____

Subscriber D.O.B. _____

Insurance Co. Phone # _____

Dental Insurance Information

Primary Insurance

Insurance Company _____

Subscriber Name _____

Subscriber D.O.B. _____

Insurance Co. Phone # _____

Subscriber's Employer_____

Group #_____ Subscriber ID # _____

Patient's Relationship to Subscriber

❑ Self ❑ Spouse ❑ Child ❑ Student Dependent

Secondary Insurance (if applicable)

Insurance Company _____

Secondary Insurance Subscriber Name_____

Secondary Subscriber D.O.B. _____

Secondary Subscriber SS # _____

Insurance Co. Phone # _____

Secondary Subscriber's Employer_____

Group #_____ Subscriber ID # _____

Patient's Relationship to Subscriber:

❑ Self ❑ Spouse ❑ Child ❑ Student Dependent

Authorization

I hereby certify that the information I have given here today is correct to the best of my knowledge and that payment is due in full at the time of treatment, unless prior arrangements have been approved. I authorize release of any information relating to claims filed by DeForest Dental Services. I wish to assign benefits to DeForest Dental Services, and understand that I am responsible for any amount not covered by my insurance. Furthermore, I understand that a 24-hour notice is required to change appointments.

Patient/Guardian Signature

X_____

Date

_____

(please turn over and complete other side)

HEALTH INFORMATION

Health History

Patient Name _____

Patient Date of Birth _____

Former Dentist _____

Location _____

Phone Number _____

Last Visit _____

Personal Physician _____

Clinic Location _____

Phone Number _____

Medications

Please list any medication you are currently taking (including over-the counter medicines)

Medication	Reason

Are you currently taking any blood thinners? ❑ Yes ❑ No

Are you currently taking birth control pills? ❑ Yes ❑ No

Have you ever taken Phen-fen? ❑ Yes ❑ No

Allergies

Check all that apply:

❑ Amoxicillin ❑ Erythromycin ❑ Penicillin

❑ Anesthetics ❑ Latex ❑ Aspirin

❑ Metals/Jewelry ❑ Tetracycline ❑ Codeine

❑ Sulfa ❑ Other _____

If yes to any, please describe symptoms _____

_____

_____

Conditions

Check all that apply (past or present)

❑ Alzheimer's/Memory Loss ❑ Heart Murmur

❑ Anemia ❑ Heart Surgery

❑ Anorexia/Bulimia ❑ Hemophilia/Abnormal Bleeding

❑ Arthritis ❑ Hepatitis A B C D

❑ Artificial Joints (date_____) ❑ High/Low Blood Pressure

❑ Artificial Heart Valves ❑ HIV/AIDS

❑ Asthma/Hay Fever ❑ Kidney Problems

❑ Blood Transfusions ❑ Liver Disease

❑ Cancer/Chemotherapy ❑ Migraines

❑ Cold Sores/Herpes ❑ Mitral Valve Prolapse

❑ Congenital Heart Defect ❑ Pacemaker

❑ Diabetes ❑ Radiation Treatments

❑ Difficulty Breathing ❑ Rheumatic/Scarlet Fever

❑ Drug/Alcohol Abuse ❑ Shingles

❑ Emphysema ❑ Sinus Problems

❑ Epilepsy/Seizures/Fainting ❑ Smoking/Tobacco

❑ Gastrointestinal Disorder ❑ Snoring/Sleep Apnea

❑ Glaucoma (Narrow Angle) ❑ Stroke

❑ Headaches (Severe, Frequent) ❑ Tuberculosis

❑ Hearing impaired ❑ Tumor Growth

❑ Heart Attack ❑ Venereal Disease

❑ Other Surgeries _____

Have you been told that you need antibiotics before a dentist appointment? ❑ Yes ❑ No

Please explain _____

Are you pregnant? ❑ Yes ❑ No Due Date _____

Are you currently nursing? ❑ Yes ❑ No

Would you like to speak to the doctor privately about any health concerns? ❑ Yes ❑ No

Health Information Update

Date	Changes	No Change	Patient Initials

Date	Changes	No Change	Patient Initials