CLINTON|FAMILY|DENTAL

PATIENT INFORMATION:

Patient Legal Name:_____Preferred Name:_____

Birth Date:_____ Male:_____ Female_____ Married_____ Single_____

SS#_____ Driver's License#_____

Address:_____City:_____State:_____Zip:_____

Home Phone#:_____ Work#:_____ Cell#:_____

Employer:_____

Emergency Contact:_____ Phone#:_____

How Did You Hear Of Us?_____

PARENT/GUARDIAN INFORMATION (if patient is a minor):

Name:_____Relationship to patient:_____

Birth Date:_____ SS#_____ Drivers License#:_____

Address:_____City:_____State:_____Zip_____

Home Phone#:_____ Work#:_____ Cell#_____

DENTAL INSURANCE INFORMATION (Primary):

Policyholder's Name:_____DOB:_____SS#_____

Policyholder's Home Address:_____

Insurance Company:_____Group#_____

Policy Holder's ID#:_____ Employer:_____

Patient Relationship to Policyholder: Self_____ Spouse_____ Child_____ Other_____

I authorize payment by my insurance company directly to the dentist or Clinton Family Dental. I authorize the use of this signature on all insurance submissions. I authorize Clinton Family Dental to release all information necessary to secure the payment of benefits.

Signature_____Date _____

I understand that I am financially responsible for all charges whether or not paid by insurance. If my account must be turned over to a collection agency, a collection fee of 30% of the outstanding balance will be added to my account. In addition, I will be responsible for any legal fees, court cost, and attorney fees.

Signature_____Date_____

CLINTON | FAMILY | DENTAL

Patient Name: _____

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If Yes, # of weeks ☐
☐	☐	Are you nursing?

Please answer the following:

Y	N		
☐	☐	Do you smoke or use tobacco?	Height:
For Office Use Only BP: ☐ Heart Rate: ☐			Weight:

Y	N	Conditions
☐	☐	Artificial Heart Valve
☐	☐	Bone Condition
☐	☐	Abnormal Bleeding
☐	☐	Bisphosphonate Therapy
☐	☐	Diabetes
☐	☐	Congenital Heart Defect
☐	☐	High Blood Pressure
☐	☐	Radiation Therapy
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Bones
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Bruise Easily
☐	☐	Cancer- Chemotherapy
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells

Y	N	Conditions
☐	☐	Frequent Headaches
☐	☐	Glaucoma
☐	☐	HIV+ AIDS
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Multiple Myeloma
☐	☐	Osteoporosis
☐	☐	Pace Maker
☐	☐	Psychiatric Problems
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis

Y	N	Conditions
☐	☐	Ulcers
☐	☐	Yellow Jaundice
☐	☐	Pain In Jaw Joints
☐	☐	Sleep Apnea
☐	☐	Snoring
☐	☐	Fever Blisters

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Primary Care Physician Name_____ Phone Number_____

Please list all prescription and over-the-counter medications you are currently taking, as well as the condition for which the medication is being taken (Please attach separate medication list if necessary).

If there are any other diseases, conditions or problems that you think we should be aware of that is not covered above, please describe here: _____

_____

Notes (Office Use Only):_____

_____