Selective Dental Patient Information Form

Name _____ Date of Birth_____

Sex ____M____F Marital Status_____ Home Address _____

City _____ State _____ Zip Code_____ Email Address_____

Home Phone _____ ___Work Phone_____ Cell Phone_____

Social Security #_____ Drivers License #:_____

Spouse's Name _____Social Security # _____Date of Birth _____

Nearest relative not living with you_____ Phone #_____

Whom may we contact in case of an emergency? _____ Phone# _____

Whom may we thank for referring you to us? _____Phone# _____

Primary Care Physician_____ Phone # _____

Employer Name_____ Phone #_____

Employer Address_____

Insurance Company_____ Group #_____ID #_____

If this claim is accident related, please provide details of the accident_____

Did you sustain an injury at work? _____ Are your injuries accident related? _____

Are your covered under any other healthcare plan? _____ If so, Name and # _____

Previous dentist _____ Phone #_____

Date of Last Dental Exam _____ Reason for today's visit_____

Women only

Are you pregnant? _____ Are you nursing? _____

Medical History: Do you have or had any of the following (Please circle)

AIDS	Diabetes	Pacemaker
Anemia	Epilepsy	Psychiatric Care/Problems
Arthritis/Rheumatism	Fainting	Radiation Treatment
Artificial Heart Valves	Glaucoma	Respiratory Disease
Artificial Joints	Headaches	Rheumatic Fever
Asthma	Heart Murmur	Shortness of Breath
Back Problems	Heart Attack	Skin Rash
Bleeding Abnormalities	Heart Problems	Sinus Problems
Blood Disease	Hemophilia	Stroke
Cancer	Hepatitis	Thyroid Problems
Chemical Dependency	High Blood Pressure	Tobacco Habit
Chemotherapy	HIV	Positive Tuberculosis
Circulatory Problems	Kidney Disease	
Congenital Heart Lesions	Liver Disease	
Cortisone Treatments	Mitral Valve prolapse	

Are there any other health conditions you have that are not listed? _____

If so, please explain_____

Please list all allergies _____

Please list all medications you are taking _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or in the above information. **This information will be kept confidential.**

Signature_____ Date_____