

## Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
\_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Married \_\_\_\_\_ Single \_\_\_\_\_ Child \_\_\_\_\_ Other  
Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Employer Name/Address: \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_

## Responsible Party Insurance Information

Name of Insured: \_\_\_\_\_ Is insured a patient? \_\_\_\_\_  
Insured's Birth Date: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_  
Insured's Address: \_\_\_\_\_  
Insured's Employer Name: \_\_\_\_\_  
Patients Relationship to Insured: \_\_\_\_\_ Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other  
Insurance Plan Name and Address: \_\_\_\_\_

## Health Information

**Have you ever had any of the following? Please check those that apply:**

_____ Are you pregnant?	_____ Radiation	_____ Rheumatic Fever
_____ AIDS/HIV	_____ Fainting	_____ Stroke
_____ Abnormal Bleeding	_____ Glaucoma	_____ Tuberculosis (TB)
_____ Allergies _____	_____ Heart Disease	_____ Thyroid Problems
_____	_____ Heart Attack	_____ Pacemaker
_____ Anemia	_____ Heart Murmur	_____ Epilepsy
_____ Artificial Joints/Implants	_____ Hepatitis/Jaundice	_____ Mitral Valve Prolapse
_____ Angina	_____ High Blood Pressure	_____ Diabetes
_____ Cancer	_____ Kidney Disease	_____ Other _____
_____ Chemotherapy	_____ Liver Disease	_____
_____ Chest Pains	_____ Low Blood Pressure	_____

Are you currently taking any medications? If yes, please list: \_\_\_\_\_  
\_\_\_\_\_

Do you have a dentist of record? If yes, state name: \_\_\_\_\_

When was the last time you were examined at his/her office? \_\_\_\_\_

When was the last time you had x-rays? \_\_\_\_\_ What type of xray? \_\_\_\_\_

The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such medical care to third payors and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_