

Patient Information Form

Last Name _____, First Name _____ Spouse's Name: _____
 Middle Name _____ Parent/Guardian's Name: _____
 Address: _____
 City, State, Zip: _____

Contact Phone #'s
 1st Preference: _____ Home Work Cell
 2nd Preference: _____ Home Work Cell
 3rd Preference: _____ Home Work Cell
 Email Address: _____

Sex Marital Status Social Security #
 Male Female Single Married Divorced Widowed _____
 Birth date: _____

Whom may we thank for referring you to our office? _____
 Yellow Pages TV Billboard Friend/Family Location Employee Insurance Co. Other

What is your reason for seeking dental treatment today? _____

Previous Dentist's Name _____ City _____ State _____

Patient's PRIMARY Dental Insurance:

Employer Name: _____ Employee name: _____
 Insurance Company: _____ ID#: _____
 Group #: _____ Soc Security of Insured: _____
 Birth date of Insured: _____ Medical Insurance Co: _____

Patient's SECONDARY Dental Insurance: (if listed on spouse's dental policy)

Employer: _____ Employee: _____
 Insurance Company: _____ ID#: _____
 Group #: _____ Soc Security of Insured: _____
 Birth date of Insured: _____ Medical Insurance Co: _____

In Case of Emergency, contact: Name: _____ Phone: _____

Authorization and Release

I authorize Drs. Belasco, Ober & Associates, P.C. to file claims to my insurance company and to use the signature below as my authorized signature for claims of dental/medical benefits for the above provider and patient for professional services rendered. I also authorize the release of any of my medical records necessary or requested for the processing of related insurance claims.

I acknowledge that a copy of this office's Notice of Privacy Practices for Protected Health Information (HIPAA) containing a description of the uses and disclosures of my personal and health information has been made available to me.

I hereby authorize Drs. Belasco, Ober & Associates, P.C. to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental/medical care.

I am the: (check one)
 Adult Patient
 Parent
 Guardian

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medications change, I will inform the dentist at the next appointment without fail. By signing below I also agree to be responsible for payment of all services rendered to the patient named above.

Signature: _____ Date: _____

Reviewing Dr.'s Initials: _____

Health History Form

1. Have you ever experienced any of the following? (please check)

- | | | |
|---|---|--|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Colitis | <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Congenital Heart | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cosmetic Surgery | <input type="checkbox"/> HIV+ / AIDS |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Heart Surgery |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hepatitis A, B or C |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Cancer / Chemotherapy | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Joint Replacement |
-
- | | |
|---|--|
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Mitral Valve Prolapse/Heart Murmur | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Pneumocystis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Seizures | |

Do you have any other conditions / problems not covered above? Yes No

If yes, please describe: _____

2. Are you under a physician's care?

Physician's Name: _____ Physician's Phone #: _____

3. Please list all Prescription and Non-Prescription medication

Why do you take each medication?

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

If you need more room, please ask for our longer form.
 You may also bring us a photocopy your medications, if you prefer.

5. Miscellaneous

Yes No
 Do you smoke or use tobacco?
 Height: _____ Weight: _____

4. Allergies – please circle all that apply

- | | | |
|--------------------|--------------|--------------|
| Aspirin | Erythromycin | Metals |
| Codeine | Jewelry | Penicillin |
| Dental Anesthetics | Latex | Tetracycline |

Other: _____

6. For women only...

Yes No
 Are you taking Birth Control Pills?
 Are you pregnant?
 Are you nursing?

