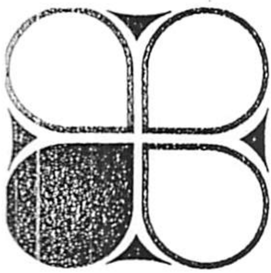

pecantreedental

PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Patient Name____
Last First MI (Preferred)

Birthdate__________ SS#____________________ DL# __________ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Work Phone________________ Wireless Phone__________________ Email____________________

If patient is under 18 yrs, please also complete the following:

*Guarantor Name*____
Last First MI (Preferred)

*Birthdate*__________ *SS#*____________________ *DL#* __________ *Gender: [ ] M [ ] F* *Married: [ ] Y [ ] N*

Work Phone________________ Wireless Phone__________________ Email____________________

Preferred contact method [ ] Hm Phone [ ] Wk Phone [ ] Wireless Ph [ ] Email

Student status if dependent over 19 (for ins) [ ] Nonstudent [ ] Fulltime [ ] Part time

How did you hear about us? (Please be specific so we can thank them!)____________________

ADDRESS AND HOME PHONE

Check box if same for entire family [ ]

Address____

Address 2____

City__________________________ State________Zip________________

Home Phone________________________

INSURANCE POLICY 1

Patient relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Sub. Name________________________________Sub.ID #____________________Sub.DOB__________

Insurance Company ______________________________________Phone____________________

Employer__________________________Group Name____________________Group #______________

INSURANCE POLICY 2

Patient relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Sub. Name________________________________Sub.ID #____________________Sub.DOB__________

Insurance Company ______________________________________Phone____________________

Employer__________________________Group Name____________________Group #______________

*Comments:*____

Please complete reverse side.

FINANCIAL AGREEMENT

For my convenience, this office may release information to my insurance and receive payments directly from them. Every effort will be made to collect payment from my insurance. I understand that this is only an estimate, and if they do not pay as expected, I am responsible. I acknowledge that there will be a $50 .00 management fee for every 30 days my account is past due. I acknowledge that I will be charged a $50.00 cancellation fee if cancelling or breaking an appointment with less than 24 hrs notice.

MEDICAL HISTORY

Name of Medical Doctor: ____________________ Doctor City / State: ____________________

Emergency Contact: ____________________ Emergency Phone Number: ____________________

List Medications You Are Now Taking:

____

____

____

____

____

Check Which Of The Following You Are Allergic To:

- ☐ None
- ☐ Aspirin
- ☐ Codein / Narcotics
- ☐ Aspirin
- ☐ Metals
- ☐ Anesthetics
- ☐ Penicillin
- ☐ Sulfa Drugs

Other: ____________________

Check Any Medical Conditions You Have Had:

- ☐ None
- ☐ AIDS / HIV
- ☐ Alcohol / Drug Abuse
- ☐ Anemia / Leukemia
- ☐ Anorexia / Bulimia
- ☐ Arthritis
- ☐ Asthma / Hay Fever
- ☐ Blood Clot Problems
- ☐ Blood Transfusion
- ☐ Brinchitis
- ☐ Cancer / Tumor
- ☐ Pacemaker
- ☐ Chest Pain
- ☐ Damaged Heart Valve
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting / Seizures
- ☐ Fever Blister / Herpes
- ☐ Frequent Headaches
- ☐ Dry Mouth / Sjogren
- ☐ Gall Bladder Trouble
- ☐ Heart Attack / Stroke
- ☐ Heart Disease / Angina
- ☐ Heart Murmur
- ☐ Hepatits / Jaundice
- ☐ High Blood Pressure
- ☐ Hives / Skin Rash
- ☐ Joint Replacement
- ☐ Kidney / Bladder Trouble
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Health Problems
- ☐ Mitral Valve Prolapse
- ☐ Persistent Diarrhea
- ☐ Rheumatic Fever
- ☐ Rheumatic Heart Disease
- ☐ Sexually Transmitted Disease
- ☐ Sinus Trouble
- ☐ Stomach Ulcers
- ☐ Thyroid Problems
- ☐ Tuberculosis

Other: ____________________

Do you use tobacco? If so, what kind and how much? ____________________

Do you have any unusual reactions to dental injections? ____________________

Are you pregnant or have any reason to believe you may be? ☐ Yes ☐ No

Question	Yes	No
Do you take vitamin supplements?	☐ Yes	☐ No
Do you purchase primarily organic foods?	☐ Yes	☐ No
Do you take mealth replacement shakes?	☐ Yes	☐ No
Do you take weight loss supplements?	☐ Yes	☐ No
Do you take work out supplements?	☐ Yes	☐ No
Do you drink energy drinks?	☐ Yes	☐ No

Question	Yes	No
Do you wish your smile was prettier?	☐ Yes	☐ No
Do you have crooked teeth?	☐ Yes	☐ No
Do you have any missing teeth?	☐ Yes	☐ No
Do you have any dental pain?	☐ Yes	☐ No

Reason for today's visit:

By signing below I certify that all of the above information is true to the best of my knowledge.

____________________ ____________________ ____________________

Name of Patient / Guardian (printed) Signature Date