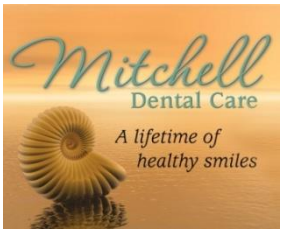

3168 Braverton Street, Suite 380, Edgewater, MD 21037 * Phone: 410-956-8380 * Fax: 410-956-8382

PATIENT INFORMATION FORM

Date ____/____/____

Patient Name: _____
Last First Preferred Name MI Title(Mr./Mrs./Ms)

Home Address: _____
Street City State Zip

Phone (Home):_____ (Work): _____ (Cell): _____

Sex: ☐Male ☐Female Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed

SS#: _____-_____-_____ Date of Birth: _____/_____/_____ Email: _____

Referred by: _____

How did you hear about us? (new patients only): ☐Yellow Pages ☐ Newspaper ☐ Flyer ☐ Other: _____

Employer: _____
Name Street/ City/ State/ Zip

Do have a preferred Pharmacy? _____
Name Location Phone

RESPONSIBLE PARTY

Who is responsible for Account?_____ Sex: ☐Male ☐Female
Last First Middle

Relation to Patient: _____ SS#: ____-____-_____ DOB: ___/____/___ Status: ☐Married ☐Single ☐Divorced ☐Widowed

Address/phone if different from Patient:_____ _____
Street/City/State/Zip Phone

☐**Patient does not have dental insurance**

PRIMARY INSURANCE COVERAGE

If patient has dental insurance please complete information below

Subscriber: _____
Name Street/City/State/Zip Phone

Relation to Patient: _____SS#: _____-_____-_____ DOB:____/____/_____ Sex: ☐Male ☐Female

Insurance Company:_____
Name Street/City/State/Zip Phone

Group #:_____ Insurance ID # _____ Employer: _____

SECONDARY INSURANCE COVERAGE

Subscriber: _____
Name Street/City/State/Zip Phone

Relation to Patient: _____SS#: _____-_____-_____ DOB:____/____/_____ Sex: ☐Male ☐Female

Insurance Company:_____
Name Street/City/State/Zip Phone

Group #:_____ Insurance ID # _____ Employer: _____

PATIENT HEALTH INFORMATION

Patient's Name _____

☐Yes ☐No **Are you under a Physician's care?** Physician's Name:_____
If Yes, please explain: _____ Physician's Phone: _____
_____

☐Yes ☐No **Allergies/Drug Sensitivities?** *If yes, please list including reaction.*
Drug _____/ Reaction _____ Drug _____/ Reaction _____
Drug _____/ Reaction _____ Drug _____/ Reaction _____
Drug _____/ Reaction _____ Drug _____/ Reaction _____

☐Yes ☐No **Do you use Antibiotic PreMed for Dental Procedures?**

☐Yes ☐No **Have your ever smoked or used tobacco?**

If Female, please answer the following:
☐Yes ☐No **Are you taking Birth Control Pills?**

☐Yes ☐No **Are you pregnant? If Yes, # of weeks** _____

☐Yes ☐No **Are you nursing?**

Are you allergic to?

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

Other _____

Medical History

Y	N	**Conditions**
☐	☐	Abnormal Bleeding
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Joints
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer-Chemo-Radiation
☐	☐	Chemical Dependency
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Emotional Disability
☐	☐	Fainting Spells
☐	☐	Fever Blisters/Cold Sores
☐	☐	Fibromyalgia
☐	☐	Frequent Headaches
☐	☐	HIV Positive
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis
☐	☐	High Blood Pressure
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Mitral Valve
☐	☐	Osteoporosis
☐	☐	Pace Maker
☐	☐	Premedication
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis

☐Yes ☐No **Are you currently taking any prescription medications/over-the-counter medications?**
If yes, please explain: _____

☐Yes ☐No **Do you have any other conditions/problems not covered above?**
If yes, please explain: _____

☐Yes ☐No **Have you ever had any complications following dental treatment?**
If yes, please explain: _____

☐Yes ☐No **Have you been admitted to a hospital or needed emergency care during the past two years?**
If yes, please explain: _____

RESPONSIBLE PARTY FOR PATIENT:
To the best of my knowledge, all the preceding answers and information provided are true and correct.

Signature: _____ Date:_____/_____/_____
Please write any additional insurance information on the back of this form - Thank You!