PATIENT INFORMATION

i Dental
Family Dentistry

Patient's name **Birth date**

If minor, parent's name Home phone Cell phone

Mailing address City State Zip

Employer Occupation E-Mail

Whom may we thank for referring you to our office?

DENTAL HISTORY

How can we help you today (Reason for Today's Visit)?

When was your last Dental Cleaning? When was your last Dental Visit?

INSURANCE INFORMATION (Insured Patient Only)

Dental Insurance Co. Subscriber Name

Subscriber ID or SSN Subscriber Date of Birth

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to WJLee DDs (dba i Dental) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible party signature: date:

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following? (Please check any that apply)

☐ Cancer or tumor
☐ Heart ailment or angina
☐ Heart murmur, mitral valve prolapse, heart defect
☐ Rheumatic fever or rheumatic heart disease
☐ Artificial joint or valve
☐ High or low blood pressure
☐ Pacemaker
☐ Tuberculosis or other lung problems
☐ Kidney disease
☐ Hepatitis or other liver disease
☐ Blood transfusion
☐ Diabetes
☐ Neurologic condition
☐ Epilepsy, seizures, or fainting spells
☐ Emotional condition
☐ Arthritis
☐ Herpes or cold sores
☐ AIDS or HIV positive
☐ Migraine headaches or frequent headaches
☐ Anemia or blood disorders
☐ Abnormal bleeding after extractions, surgery, or trauma
☐ Hayfever or sinus trouble
☐ Allergies or hives
☐ Asthma
Do you smoke or use chewing tobacco? ☐ yes ☐ no

Are you allergic to, or have you reacted adversely to any of the following?
☐ Latex materials
☐ Penicillin or other antibiotics
☐ Local anesthetics ("Novocain")
☐ Codeine or other narcotics
☐ Sulfa drugs
☐ Barbiturates, sedatives, or sleeping pills
☐ Aspirin
☐
Other:_____

List all Medications you are currently taking:

_____

_____

_____

_____

Women:
☐ May be pregnant Expected delivery date:
_____
☐ Taking hormones or contraceptives

Please add anything else you would like us to know about (disease, condition, problem, etc.)

_____

Patient Signature **Date** **Doctor Signature** **Date**