PATIENT INFORMATION FORM

Patient Name____ #SS _________________________
Street Address________________________________ City/State_______________ ZIP__________
Home Phone _____________________Marital Status: S M W D Sep. Birth Date___________
Patient Employer_______________________________ Occupation_________________________
Years Employed ____________ Business Phone____________ Cell Phone__________________
Employer Address____________________________ City/State_______________ ZIP__________
E-Mail Address____
Spouse/Parent Name_________________________ #SS _________________ Birth Date________
Spouse/Parent Employer _______________________________ Occupation__________________
Years Employed_______________ Business Phone______________
Employer Address ____________________________ City/State_______________ ZIP_________

IF A STUDENT PLEASE COMPLETE THE FOLLOWING:

Name of responsible party___________________________________Phone_______________
Address_______________________________ City/State_______________ ZIP_________

Has any member of your immediate family been treated by this practice before? ☐ Yes ☐ No
Name of person who referred you to this practice _____________________________________

PLEASE COMPLETE THE FOLLOWING IF YOU ARE COVERED BY A DENTAL INSURANCE POLICY

Copy of Insurance card necessary

Insured person______________________________ #SS_________________ Birth Date________
Mailing Address_____________________________ City/State _______________ ZIP__________
Carrier Name___________________________ **Group#**_____________ **Policy#**_________________
Employer_____________________________________

Co-Insurance ☐ **Yes** ☐ **No** **Copy of Insurance card necessary**

If yes, complete the following:
Insured person______________________________ #SS_________________ Birth Date________
Mailing Address_____________________________ City/State _______________ ZIP__________
Carrier Name___________________________ **Group#**_____________ **Policy#**_________________
Employer_____________________________________

THE PATIENT IS RESPONSIBLE FOR FURNISHING DENTAL INSURANCE INFORMATION TO OUR OFFICE. PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE. PAYMENT IS EXPECTED DAY OF SERVICE FOR PATIENT PORTION OF CHARGES AND FEES FOR SERVICES RENDERED NOT COVERED BY INSURANCE.

Patient is requested to notify office at least 24 hours prior to changing a scheduled appointment.

Insurance Authorization and Assignment:

I hereby authorize **Jason Annan, DDS** to furnish information to insurance carriers concerning
My claim and I hereby assign all payments for dental services rendered to myself or my dependents.
I understand I am responsible for any amount not covered by Insurance.

Patient Signature_______________________________________ Date_________________

MEDICAL HISTORY

Please ✓ the correct ☐

1. Are you presently being treated by a physician? ☐ Yes ☐ No
   If yes, for what reason?____

2. Are you allergic to any medications? ☐ Yes ☐ No
   If yes, for what reason?____

3. Have you ever taken penicillin ? ☐ Yes ☐ No
4. Have you ever been told you bleed easily? ☐ Yes ☐ No
5. Have you ever been treated for any type of cancer? ☐ Yes ☐ No
6. Do you take birth control pills? ☐ Yes ☐ No
7. Are you presently taking any medication (prescribed, over the counter, herbal remedies, vitamins, aspirin ect.) ☐ Yes ☐ No
8. Do you have or have you had any of the following?
   If yes, please put a ✓ in the ☐

		☐ Asthma
☐ Anemia	☐ Kidney problems	☐ Hip or Joint Replacement
☐ Diabetes	☐ Rheumatic Fever	☐ Radiation Treatments
☐ Arthritis	☐ Sickle Cell Anemia	☐ Vincent's (Trench Mouth)
☐ Ulcer	☐ Abnormal Blood Pressure	☐ Food Allergies
☐ Sinusitis	☐ Irregular Heart Beat	☐ Abnormal Heart
☐ Tuberculosis	☐ Hepatitis	☐ Heart Valve Problem
☐ Cancer	☐ Other____________________	

9. Any recent hospitalizations or medical procedures? ____________________________________

10. Have you used Novocain (Xylocain) ? ☐ Yes ☐ No
    If yes, have you ever had any problems resulting from its use? ☐ Yes ☐ No
    If yes, please explain the problem____

11. How long has it been since you have last seen a Dentist? ________________________________

12. At that time were you satisfied with the treatment? ____________________________________

13. Are you currently having a dental problem or dental pain? ☐ Yes ☐ No
    If yes, please explain the problem____

MEDICATION FORM

PLEASE LIST ALL MEDICATION

Prescribed medications, over the counter medications, herbal remedies, vitamins¸ etc.)

Name of Medication	Amount	How Often