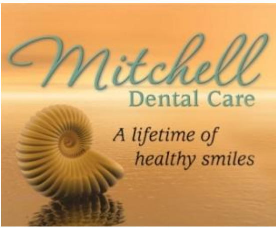

3168 Braverton Street, Suite 380, Edgewater, MD 21037 * Phone: 410-956-8380 * Fax: 410-956-8382

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? ☐ Internet ☐ Phone book ☐ Flyer/Ad ☐ Other: _________________________

Employer: ____
Name Street/ City/ State/ Zip

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 ____

Who is your Primary Care Physician? Name:____________________________________ Phone: _____________________

When was your last medical appointment? _____________________ When was your last physical? _____________________

☐Yes ☐No **Allergies/Drug Sensitivities?**

☐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	
☐	☐	Penicillin	☐	☐	Dental Anesthetics
☐	☐	Amoxicillin	☐	☐	Codeine
☐	☐	Clindamycin	☐	☐	Latex
☐	☐	Erythromycin	☐	☐	Jewelry
☐	☐	Tetracycline	☐	☐	Metals

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
☐	☐	Mental Health Condition
☐	☐	Anxiety/Depression
☐	☐	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!