Creekside Dental
"We love to see you smile"

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Confidential Patient Information – I

(Please Print Legibly)

Date: _____

Personal Information

Name: _____ SS #: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work) _____

(Cell) _____ e-mail: _____

Birth date: _____ Sex: _____ Marital Status: _____ Spouse Name: _____

Occupation: _____ Referred by: _____

Person Responsible for Account

Name: _____ Relationship: _____ SS #: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work) _____

Dental Insurance Information

Primary Insurance Co: _____

Insurance Co. Address: _____

Employee: _____ Relationship: _____ S.S. #: _____

Employer: _____ Policy #: _____

Secondary Insurance Co: _____

Insurance Co. Address: _____

Employee: _____ Relationship: _____ S.S. #: _____

Employer: _____ Policy #: _____

I understand that payment is my obligation regardless of insurance or any other third-party involvement.

_____ _____

PATIENT'S NAME **DATE**

Confidential Patient Information – II

(Please Print Legibly)

Patient Name: _____ Initial Date: _____

Physician's Name and Contact Info: _____

New Patients: When was your last dental visit? _____ Where? _____

Have you had any major operations? (joint replacements, heart surgery, etc.) _____

Are you currently taking or have you taken Bishosphonate (Fosamax, Boniva, Actonel, etc.)? ☐ Yes ☐ No

Please list current medications: _____

_____

Do you use/have used tobacco? ☐ Yes ☐ No Do you use/have used controlled substances? ☐ Yes ☐ No

Women: Are you ☐ pregnant/trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Metal/Jewelry ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Latex ☐ Local Anesthetics ☐ Other

Circle Any of the Following Conditions That You Have Had or Now Have

A. AIDS
B. Arthritis
C. Asthma
D. Cancer
E. Diabetes
F. Epilepsy
G. Glaucoma
H. Heart Murmur
I. Heart Problem
J. Hepatitis
K. High Blood Pressure
L. Jaundice
M. Kidney Problems
N. Low Blood Pressure
O. Nervous Breakdown or Psychiatric Therapy
P. Osteoporosis
Q. Rheumatic Fever
R. Sexually Transmitted Diseases
S. Stroke
T. Tuberculosis
U. Other Diseases

Have you ever had any serious illness not listed above? _____

Comments: _____

_____

Person to Be Contacted in Case of Emergency (Other Than Relative)

Name: _____

Address: _____

Telephone: (Home) _____ (Work) _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

X _____

SIGNATURE OF PATIENT, or GUARDIAN DATE

_____

SIGNATURE OF DOCTOR OR HYGIENIST DATE