

# Patient Information & Health History

## ABOUT PATIENT

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Middle Initial

\_\_\_\_\_  
Preferred Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Street Address (including Apartment No.)

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Home Telephone Number

\_\_\_\_\_  
Cell Telephone Number

\_\_\_\_\_  
Work Telephone Number (including Extension)

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Driver's License No. / State / Expiration Date

\_\_\_\_\_  
Best Telephone Number & Time to Call

\_\_\_\_\_  
Employer Name

\_\_\_\_\_  
Employer Street Address (including Suite Number)

\_\_\_\_\_  
Employer Address (City, State, Zip Code)

Status:  Married  Single  Child  Other

NOTE: Present Picture Identification (Driver's License) to Patient Services Coordinator to Copy

## PRIMARY INSURANCE

\_\_\_\_\_  
Subscriber's Name (Last, First, M.I.)

\_\_\_\_\_  
Subscriber's Date of Birth

\_\_\_\_\_  
Subscriber's Social Security Number

\_\_\_\_\_  
Insurance Carrier's Name & Telephone Number

\_\_\_\_\_  
Subscriber's I.D. Number (if different from S.S.N.)

\_\_\_\_\_  
Group Number

\_\_\_\_\_  
Employer Name

NOTE: Present Insurance I.D. Card(s) to Patient Services Coordinator to Copy

## RESPONSIBLE PARTY FOR ACCOUNT

(if different from patient)

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Middle Initial

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Street Address (including Apartment No.)

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Home Telephone Number

\_\_\_\_\_  
Driver's License No. / State / Expiration Date

\_\_\_\_\_  
Cell Telephone Number

\_\_\_\_\_  
Work Telephone Number (including Extension)

\_\_\_\_\_  
Employer Name

\_\_\_\_\_  
Employer Street Address (including Suite Number)

\_\_\_\_\_  
Employer Address (City, State, Zip Code)

\_\_\_\_\_  
Best Telephone Number & Time to Call

\_\_\_\_\_  
Full Name of Patient's Parent/Legal Guardian (if Different from Above)

\_\_\_\_\_  
Address of Patient's Parent/Legal Guardian (if Different from Above)

\_\_\_\_\_  
Home Phone # of Patient's Parent/Guardian (if Different from Above)

\_\_\_\_\_  
Work Phone # of Patient's Parent/Guardian (if Different from Above)

## SECONDARY INSURANCE

\_\_\_\_\_  
Subscriber's Name (Last, First, M.I.)

\_\_\_\_\_  
Subscriber's Date of Birth

\_\_\_\_\_  
Subscriber's Social Security Number

\_\_\_\_\_  
Insurance Carrier's Name & Telephone Number

\_\_\_\_\_  
Subscriber's I.D. Number (if different from S.S.N.)

\_\_\_\_\_  
Group Number

\_\_\_\_\_  
Employer Name

**REFERRAL**

Whom may we thank for referring you to the office?

- Another Patient or Relative (Please Provide Name & Address): \_\_\_\_\_
- Website /  Internet (Google, Yahoo Search) / Yellow Pages:  Chattanooga or  Other (Specify) \_\_\_\_\_
- Office Sign /  T.V. Ad /  Other (Specify) \_\_\_\_\_

**HEALTH**

Injury to Face/Jaw (If yes, provide date & description): \_\_\_\_\_

Have you been admitted to a hospital or needed emergency treatment in the past two (2) years? If yes, please describe: \_\_\_\_\_

Have you ever had complications from prior dental treatment?  Yes  No If yes, describe: \_\_\_\_\_

Have you ever had complications from dental anesthetic(s)?  Yes  No If yes, describe: \_\_\_\_\_

Use, or have used, tobacco in any form?  Yes  No

Use, or have used, diet pills or weight loss medications?  Yes  No

Use, or have used, alcohol?  Yes  No

Use, or have used, recreational drugs?  Yes  No

Use, or have used, medication(s) for Osteoporosis?  Yes  No

List all medications you are taking, with the amount and frequency of each, below (including Prescription & Over-the-Counter, such as aspirin, Goodies or BC Powders, Ibuprofen, Tylenol, Herbal Healthcare Products, Vitamins, etc.):

\_\_\_\_\_  
 \_\_\_\_\_

Primary Care Physician Name & Telephone Number: \_\_\_\_\_

Emergency Contact (Name, Telephone Number & Relationship): \_\_\_\_\_

Do you have, or have you ever had, any of the following conditions or treatments (check all that apply)?

<input type="checkbox"/> Allergies (Environmental)	<input type="checkbox"/> Angina	<input type="checkbox"/> Anorexia, Bullemlia	<input type="checkbox"/> Artificial Joints &/or Bone	<input type="checkbox"/> Asthma
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Congestive/Enlarged Heart	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Endocarditis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Fainting	<input type="checkbox"/> Fen Phen Valvular Damage
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Bypass	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Immune System Suppression	<input type="checkbox"/> Implant/ Graft Artery or Vein	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Kidney Dialysis	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Marfan's Syndrome	<input type="checkbox"/> Mental Disorders	<input type="checkbox"/> MVP (Mitral Valve Prolapse)	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> MS (Multiple Sclerosis)	<input type="checkbox"/> Nervous Disorders	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Parkinson's	<input type="checkbox"/> Pregnancy (Current)
<input type="checkbox"/> Radiation	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Steroid Treatments	<input type="checkbox"/> Stomach Problems	<input type="checkbox"/> Stroke	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/> Take Blood Thinner	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Transplanted Organ	<input type="checkbox"/> Tuberculosis (TB)	<input type="checkbox"/> Tumors
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Valve Defect Surgery	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Codeine Allergy	<input type="checkbox"/> Penicillin Allergy
Allergy to:	<input type="checkbox"/> Snoring	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Yeast/Fungus Infections	<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Latex	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Birth Control Pills	<input type="checkbox"/> Other Conditions, Treatments or Medication Allergies (Describe): _____	
<input type="checkbox"/> Dental Anesthetic	<input type="checkbox"/> Seizures	<input type="checkbox"/> Wear Contacts		
<input type="checkbox"/> Metal(s)	<input type="checkbox"/> Osteoporosis (List Medications): _____			

To the best of my knowledge, all the preceding answers and information are true and correct. If I ever have any change in my health, I will notify the doctor at my next appointment, without fail.

\_\_\_\_\_  
 (Patient Signature or Signature of Parent / Legal Guardian)

\_\_\_\_\_  
 (Date)