PATIENT INFORMATION

(Please Print)

Date _____Social Security # _____ Sex: ❑ M ❑ F Birthdate: _____ Age: _____

Patient Name _____
Last First Initial Preferred name

Street Address _____City_____State_____Zip_____

Home phone: _____ Work phone:_____ Cell phone:_____
Which number is best to reach you? ❑ Home ❑ Work ❑ Cell Email:_____

Your Employer's Name: _____ Occupation: _____

If you carry dental insurance, who is the subscriber? _____
Name of Dental Insurance Company _____ Group # _____

Spouse's Name: _____ Birthdate: _____SS#_____
Spouse Employed by: _____ Occupation: _____

Your Physician's Name: _____ Phone # _____

In case of emergency, who should be notified? _____ Phone _____

Have you ever had any of the following? (check only boxes that apply) **If none apply <u>WRITE</u> none_____**

❑ Heart Problems	❑ Circulatory Problems	❑ Headaches	❑ Ulcer
❑ Heart Murmur	❑ Nervous Problems	❑ Recent Weight Loss	❑ Allergies to Anesthetics
❑ High Cholesterol	❑ History of Cancer	❑ Back Problems	❑ General Allergies
❑ Rheumatic Fever	❑ Radiation Treatment	❑ Arthritis	❑ Special Diet
❑ Epilepsy/Seizures	❑ Hepatitis Type ____	❑ Sinus Problems	❑ Venereal Disease
❑ Diabetes	❑ Liver Disease	❑ Stroke	❑ Chemical Dependency
❑ Respiratory Disease	❑ Kidney Disease	❑ High/Low	❑ AIDS / Immunosuppressive
❑ Artificial Valve/Joints	❑ Smoking/Chewing Tobacco	❑ Blood Pressure	Disorders

Do you have any drug allergies or have you ever had any adverse reaction to any medication? _____
If yes, what _____
Have you ever responded adversely to medical or dental treatment? _____
Are you under the care of a physician? ❑ No ❑ Yes For what condition? _____
Are you taking any medication at this time? _____If yes, please list _____
If patient is a child, what is his/her weight? _____
Women: Do you suspect that you are pregnant? ❑ No ❑ Yes Are you nursing? ❑ No ❑ Yes
Is there any other information we should know about your medical history? _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____and assign directly to <u>Dr. Kelly Walker</u> 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. Any cost incurred by this office during the collection process will be my responsibility. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Sign Date Relationship