## Patient Information

Name:_____Date of Birth: _____ Sex: M F

Mailing Address:_____

Apt#_____City:_____State:____ Zip:_____

Soc. Sec. # _____ Cell #:_____

Home #: _____Email Address: _____

Employer:_____ City: _____ Bus. Phone: _____

Regular Dentist:_____ Referring Dentist: _____

Physician: _____ Your general health (circle one): Good Fair Poor

In case of emergency, whom should we contact? _____ Relationship: _____

Emergency Contact Phone #: _____

## Dental Insurance

Primary Insurance Company: _____ Are you the subscriber? YES NO

Subscriber's Name (If not the patient): _____Subscriber's birthday: _____

ID#: _____ Group #: _____

*NOTE: We will file a claim for you but it is your responsibility to pay any co-insurance, deductible amount or balance not paid for by your insurance company, at the time of service.*

## Medical History

Please check any of the following conditions that you currently have or have had in the past:

| | | | |
|---|---|---|---|
| _____Heart Condition | _____Hemophilia | _____Hepatitis/Liver Disease | _____Cancer/Tumor |
| _____Heart Attack/Stroke | _____Lung Disease | _____Thyroid Disease | _____Radiation Therapy |
| _____Heart Murmur | _____Tuberculosis | _____Glaucoma | _____Chemotherapy |
| _____Artificial Heart Valve | _____Asthma | _____Cortisone Medicine | _____AIDS, ARC, HIV+ |
| _____Heart Pacemaker | _____Kidney Trouble | _____Phen-Fen/Redux | _____Epilepsy/Seizures |
| _____Rheumatic Fever | _____Diabetes | _____Drug/Alcohol Addiction | _____Anxiety/Depression |
| _____Artificial Joint | _____Sickle Cell | _____High Blood Pressure | _____Osteoporosis |

List any diseases, conditions or problems not noted above: _____

List any medication you are currently taking: _____

_____

ALLERGIES: Please check any of the following allergies you have or have had in the past:

_____Penicillin or other antibiotics _____Codeine or other narcotics

_____Latex (Rubber) _____ Other: _____

Have you ever had a complication during or after dental treatment: YES, NO If yes, what? _____

For Women: Are you pregnant or do you think you may be pregnant? YES, NO Due Date: _____

Are you on birth control? YES NO

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I authorize my insurance company to issue payment directly to Martin Nelson Endodontic Group. I authorize the use of this signature for all insurance claims. I understand I am responsible for all fees not covered by my insurance. I will not hold Martin Nelson Endodontic Group responsible for any complications that result from any errors or omissions that I may have made.

Signature of patient/guardian:_____Date: _____

***I hereby acknowledge that I have received/read a copy of this office's HIPAA Notice of Privacy Policy or can ask for a copy. I have been given the opportunity to ask any questions regarding this Notice.***