Confidential Patient Information

Date: _____

PATIENT NAME: _____
(Last) (First) (Middle)

Address_____
City State ZIP

Home Phone: ( ) _____ Mobile Phone ( ): _____

Email (for appointment confirmations): _____

Place of Employment_____Occupation_____

Business Address _____
City State ZIP

Business Phone: ( ) _____-_____

Date of Birth _____/_____/_____ SS# _____ - _____ - _____ Male_____ Female ____

Marital Status ___Single ___Married ____Divorced ____Widowed

SPOUSE: Name_____ Date of Birth: _____
Address if different from above

Place of Employment_____Occupation_____

Person Responsible for Account_____
Address if different from above

How did you hear about our office? Insurance List WCNC Internet Search Pandora Local Saver

If patient or staff member referral, whom may we thank? _____

Has any member of your family been treated in our office previously? ____ Yes ____ No (Relationship) _____

Why did you choose Dr. Prevette as your dentist? _____

Reason for Visit: _____

DENTAL HEALTH: Please check one ❑ Excellent ❑ Good ❑ Fair ❑ Poor

What priority do you give your teeth (10 being highest)? 1 2 3 4 5 6 7 8 9 10

MEDICAL HEALTH: Please check one: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Physician's Name: _____

Last complete physical? _____Are you under a doctor's care now? _____If yes, for what reason?

_____

Please list any medications, pills or drugs you are taking: _____

_____

_____

Have you ever received a blood transfusion? ____Yes ____No When? _____
Are you subject to fainting spells? ____Yes ____No Are you pregnant? _____ How long? _____
Are you subject to prolonged bleeding? ____Yes ____No

(OVER)

MEDICAL HEALTH, continued

Are you allergic to: ❑ Penicillin ❑ Codeine ❑ Local anesthetics ❑ Other medications – list below:

_____

Please CIRCLE if you have or have had any of the following:

Heart trouble	Fainting or Dizziness	Hepatitis B (serum)
High Blood Pressure	Stroke	Recent Weight Loss
Low Blood Pressure	Diabetes	Cancer
Heart Murmur	Artificial Joints/Hips	Thyroid Disease
Rheumatic Fever	Kidney Trouble	Parathyroid Disease
Congenital Heart Lesion	Ulcers	X-Ray or Cobalt Tmt.
Artificial Heart Valve	Allergies	Chemotherapy/Radiation
Heart Pacemaker	Asthma	Arthritis/Gout
Heart Surgery	Hay Fever	Glaucoma
Mitral Valve Prolapse	Sinus Trouble	Prostate
Blood Disease	Emphysema	Epilepsy/Seizures
Anemia	Frequent Cough	Alzheimer Disease
Chest Pain	Lung Disease	Hypoglycemia
Shortness of Breath	Liver Disease	Psychiatric Care
Swelling of Feet/Ankles/Hands	Hepatitis A (infectious)	Hemophilia
HIV Positive	Snoring	Sleep Apnea

INSURANCE: Please complete the following information regarding **DENTAL** insurance if you do **NOT** have a card with you

Primary Carrier Insurance Company: _____
Claims Mailing Address _____
Employee: _____ SS#_____ - _____ - _____
Group#_____ I.D. #_____

I authorize assignment of benefits to go to Allen Prevette, DDS _____
(Signature)

Patient's Signature_____

MEDICAL UPDATES:

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

Date	Exceptions	Patient's Signature	Reviewed By
_____	_____ None ❑	_____	_____
_____	_____ None ❑	_____	_____
_____	_____ None ❑	_____	_____
_____	_____ None ❑	_____	_____
_____	_____ None ❑	_____	_____
_____	_____ None ❑	_____	_____
_____	_____ None ❑	_____	_____
_____	_____ None ❑	_____	_____
_____	_____ None ❑	_____	_____
_____	_____ None ❑	_____	_____
_____	_____ None ❑	_____	_____