# SOULARD FAMILY DENTISTRY

## PATIENT INFORMATION

DATE _____

MR. MRS. MALE

NAME _____/_____/____ MS. DR. FEMALE _____

LAST FIRST M.I. BIRTHDATE

ADDRESS _____/_____/_____/_____ _____-____-_____

STREET CITY STATE ZIP SOCIAL SECURITY #

PHONE _____ _____ _____ E-MAIL _____

HOME WORK ALTERNATE

EMPLOYER _____ _____

NAME ADDRESS

OCCUPATION _____

SINGLE SEPARATED

REFERRED BY _____ _____ MARITAL STATUS MARRIED DIVORCED WIDOWED

## SPOUSE/PARENT INFORMATION

MR. MRS. MALE

NAME _____/_____/____ MS. DR. FEMALE _____

LAST FIRST M.I. BIRTHDATE

ADDRESS _____/_____/_____/_____ _____-____-_____

STREET CITY STATE ZIP SOCIAL SECURITY #

PHONE _____ _____ _____ E-MAIL _____

HOME WORK ALTERNATE

EMPLOYER _____ _____

NAME ADDRESS

OCCUPATION _____

## PERSON RESPONSIBLE FOR ACCOUNT (IF SAME AS ABOVE, PUT "SAME")

MR. MRS. MALE

NAME _____/_____/____ MS. DR. FEMALE _____

LAST FIRST M.I. BIRTHDATE

ADDRESS _____/_____/_____/_____ _____-____-_____

STREET CITY STATE ZIP SOCIAL SECURITY #

PHONE _____ _____ _____ E-MAIL _____

HOME WORK ALTERNATE

EMPLOYER _____ _____

NAME ADDRESS

RELATIONSHIP TO PATIENT _____

## IN CASE OF EMERGENCY (SPECIFY SOMEONE WHO DOESN'T LIVE IN YOUR HOUSEHOLD)

NAME_____ PHONE_____ RELATIONSHIP TO PATIENT_____

## INSURANCE INFORMATION

CARRIER _____ GROUP # _____ SUBSCRIBER'S NAME _____
ADDRESS_____ PHONE _____

CARRIER _____ GROUP # _____ SUBSCRIBER'S NAME _____
ADDRESS_____ PHONE _____

The above information is complete and accurate. It is my responsibility to update any changes in the above information. I understand that I am financially responsible for all charges whether or not paid by the insurance company.

SIGNATURE _____ DATE _____

# SOULARD FAMILY DENTISTRY

## HEALTH HISTORY

PHYSICIAN'S NAME _____ PHONE _____

CARDIOLOGIST'S NAME _____ PHONE _____

Please circle if you have, or have had, any of the following conditions:

Anemia
Arthritis
Artificial Heart Valves
Artificial Joints
Asthma
Back Problems
Bleeding/Clotting Problems
Cancer
Chemical Dependency
Chemotherapy
Epilepsy
Headaches
Diabetes
Last HbA1c _____

Heart problems
Hepatitis
Herpes
High Blood Pressure
HIV Positive/AIDS
HPV Positive
GERD/Acid Reflux
Jaundice
Kidney Disease
Liver Disease
Mitral Valve Prolapse
Nervous Problems
Pace Maker
Psychiatric Care

Radiation Treatment
Respiratory Disease
Sinus Problems
Skin Disease
Thyroid Problems
Tobacco Use
Ulcers
Venereal Disease

Women Are You Currently
Pregnant
Due Date? ____
Nursing
Taking Birth Control Pills

List the medications you are currently taking
_____
_____
_____
_____
_____
_____
_____

Allergies: Aspirin, Barbiturates, Codeine, Iodine, Latex, Local Anesthetics, Penicillin, Sulfa, Other_____, _____

What do you do for your overall health:

Consider the following benefits of good dental health. In order of importance to you please rank 1-4.

___ Health ___ Longevity ___ Appearance ___ Other

Consider the following concerns regarding dental care. In order of importance to you please rank 1-5.

___ Money ___ Time ___ Fear/Anxiety ___ Physical Discomfort ___ Other

The above information is complete and accurate to the best of my knowledge. I understand this information is critical to determining the best treatment for me, and it is my responsibility to update this office to changes in my heath or medications.

SIGNATURE _____ DATE _____