Eric Felt, D.D.S. Patient Information Form

Date _____

Name _____ Phone _____ Cell _____

Birth Date _____ Age _____ Sex (M/F) _____ Social Security Number _____

Address _____ City _____ Zip code _____

Email_____ May we communicate via text message with you? Yes No

Employer _____ Employer's Phone _____

Employer Address _____

Spouse's Name (if patient is a minor, parent's name) _____

Spouse's Employer _____ Spouse's Phone _____

Name of nearest adult relative not living with you _____ Phone Number_____

Who referred you to our office? _____

Insurance Information **(Fill out only if we do not have a copy of your insurance card)**

Name of Dental Insurance Plan _____

ID# _____ Group Number _____

Name of Insured _____ Insured's Social Security Number_____

Insured's Address _____ City _____ State ____ Zip code _____

Insured's Birthdate _____ Insured's Employer _____

I understand that even with insurance coverage I am still responsible for all charges on the account. (Please see our financial policy for more information). I also affirm that the information written above is correct.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please sign below to acknowledge you have received notification of the privacy policies of this dental office. (Please see sheets attached to clipboard titled, "Notice of Privacy Practices") If you wish to have a copy of the "Notice of Privacy Practices", please inquire at the front desk.

_____ _____

Signature of Responsible Party (Parent/Guardian if Minor) Date

Please Continue On the Other Side →

General Health (Please Check) Excellent _____ Good _____ Fair _____ Poor _____

1. Do you have, or have you had any of the following problems? Circle, if yes.

Heart Condition	Asthma or Severe Hay Fever	Prosthetic Valve or Joint	Radiation Therapy
Rheumatic Fever	Fainting or Seizures	Kidney Trouble	Venereal Disease
Heart Murmur	Abnormal Bleeding	Tuberculosis	HIV Positive
High Blood Pressure	Diabetes	Severe Headaches	Exhaustion
Stroke	Hepatitis or Liver Disease	Chemical Dependency	Inadequate Saliva
Allergies (except seasonal)	Rheumatism or Arthritis	Blood Disease	Frequent Vomiting
Nervous Disorder	Stomach Ulcers	Cancer or Tumor	Other (Fill In):

		YES	NO
2.	Are you now or have you been under the care of a physician during the past two years?	___	___
3.	Are you presently using ANY medications of drugs, including birth control pills?	___	___
4.	Women: Are you pregnant? If so, how many months along	___	___
5.	Have you ever experienced an allergic reaction to ANY medicine or drug?	___	___
6.	Have you experienced an unfavorable reaction to any previous dental treatment?	___	___
7.	Are your teeth sensitive to heat, cold, or sweet? Please circle any that apply	___	___
8.	Do you have a problem with food wedging between your teeth?	___	___
9.	Do you have a problem with bleeding or sore gums?	___	___
10.	Do you have frequent bad breath or an unpleasant taste in your mouth?	___	___
11.	Do you have any swelling in or around your mouth, or sores that are slow to heal?	___	___
12.	Does it ever hurt to open wide, or do you experience clicking or other noises in your jaw joint?	___	___

Briefly Describe Any Previous Question Answered with A YES

#( ) _____

#( ) _____

#( ) _____

		YES	NO
13.	Have all of your wisdom teeth been removed?	___	___
14.	Is there anything about the appearance of your teeth that you are interested in improving?	___	___

Please Describe_____

15. How long has it been since your last thorough dental examination? _____
    a. Were X-rays taken at that visit? _____
16. Reason for today's visit _____

17. Name of your Medical Doctor _____ City _____

Patient Signature _____ Date _____