Purdy Family Dentistry

We are dedicated to providing you with an efficient, respectful and comforting clinic.
Please help us by providing the following information. Thank you.

PATIENT INFORMATION:

Patient Name_____

Preferred Name_____

Date of Birth_____

Male_____ Female _____

Phone Number _____

Alternate Phone Number _____

Address_____

City/State/Zip _____

Email _____

Preferred Contact Method (please circle):

TEXT EMAIL PHONE CALL

Employed by _____

Occupation_____

Business Phone (if we are able to call you at work)

_____

Parent/Spouse Name_____

Phone_____

Emergency Contact (if different than listed above):

Name _____

Phone _____Relationship_____

How did you hear about us?

_____

PRIMARY INSURANCE INFORMATION

Policy Holder Name_____
DOB_____
Relationship to patient_____
SSN/ID_____
Name of Employer_____
Group Number _____
Name of Insurance Company

_____
Insurance Company Address

_____

Is the Policy Holder also the responsible party _____ (if so, skip Responsible Party Section)

SECONDARY INSURANCE INFORMATION

Do you have Secondary Coverage _____
Policy Holder Name_____
DOB_____
Relationship to Patient _____
SSN/ID _____
Name of Employer _____
Group Number _____
Name of Insurance Company

_____
Insurance Company Address

_____

RESPONSIBLE PARTY

Name _____
Phone _____
Relationship to Patient _____
Complete Street Address

_____

_____

ACKNOWLEDGEMENT

The above information is accurate and complete to the best of my knowledge. It is used in my treatment, billing and processing of insurance. I am responsible for any errors or omissions that I may have made in completing this form. I am also aware that Purdy Family Dentistry, in accordance with HIPAA has available to me the Notice of Privacy, if I so wish to read it before signing.

Patient Signature:

_____

Date _____

MEDICAL HISTORY

Name and phone number of Physician: _____ Last exam: _____

Are you now under the care of a physician? _____ If yes, explain: _____

Are you taking any medications? _____ **Please List:**_____

_____

Are you allergic to (**Please Circle**): ·**Penicillin** ·**Codeine** ·**Local Anesthetic** ·**Latex** ·**Metal** ·**Other**: _____

Do you have, or have you ever had any of the following? (Please circle/check):

Heart Trouble		Tuberculosis/Lung Disease		Nervous Problems	
Heart Murmur		Excessive/Prolonged Bleeding		Artificial Heart Valves	
Heart surgery/Pacemaker		Glaucoma		Artificial Joints	
Rheumatic Fever		Hepatitis, Type:		Respiratory Disease	
High/Low Blood Pressure		Psychiatric Care		Mitral Valve Prolapse	
Diabetes		Cancer/Chemotherapy/Radiation		Blood Disease	
Hemophilia		Epilepsy/Asthma/Anemia		HIV Positive/AIDS	
Swollen Neck Glands		Prosthetic Implants		Chemical Dependency	
Thyroid Problems		Stroke		Tobacco Use, Years:	

Have you had any other serious illness, hospitalization or accident? _____

(Women) - Are you pregnant? _____ **(Women)** - Are you nursing? _____

Patient Signature: _____ **Date**: _____

Staff member Signature: _____ Blood pressure _____ Pulse _____

DENTAL HISTORY

Former Dentist and phone number: _____

When was your last dental cleaning? _____ Were x-rays taken? ___

Are you aware of any dental problems? _____ Does food chronically collect between your teeth? ____

Do your gums bleed? ___ Have you ever been told you have gum disease? ____

Are your teeth acutely sensitive to: Sweet ___ Cold ___ Heat ___ Pressure ___ None ___

How often do you brush your teeth? _____ Floss? _____

Has any dental treatment been recommended to you that has not been completed at this time? _____

Are you happy with the appearance of your smile? ____ Explain _____

Anything else that would be valuable for me to know? _____