Confidential Patient Information

Kelli A. Barbee, DMD, 1830 Destiny Lane, Ste. 119, Bowling Green, KY 42104 (270)393-9925 fax (270) 393-9928

(Please Print Legibly)

Date: _____

PERSONAL INFORMATION

Name: _____ SS# _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work) _____

(Cell)_____ e-mail: _____

Birth date: _____ Sex: _____ Marital Status: _____Spouse Name: _____

Occupation: _____ Referred by: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relationship: _____ SS# _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work) _____

DENTAL INSURANCE INFORMATION

Primary Insurance Co: _____

Insurance Co. Address: _____

Employee: _____ Relationship: _____ SS#: _____

Employer: _____ Policy #: _____

Secondary Insurance Co: _____

Insurance Co. Address: _____

Employee: _____ Relationship: _____ SS#: _____

Employer: _____ Policy#: _____

I understand that payment is my obligation regardless of insurance or any other third-party involvement.

SIGNATURE: _____ DATE: _____

Confidential Patient Information – II

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(Please Print Legibly)

Patient Name: _____ Initial Date: _____

HEALTH INFORMATION

Personal Physician Name: _____

Personal Physician Address: _____

CHECK ALL THAT APPLY AND EXPLAIN:

Have you been hospitalized within the past 2 years? For what? _____

Are you currently being treated by a physician? For what? _____

Are you currently taking any medicines or drugs? What?_____

_____

_____

_____

Have you ever received counseling for excessive use of alcohol and /or prescription drugs?

Are you allergic to any drugs? What? _____

Have you ever had a skin rash or other reaction to metal jewelry? To what? _____

Are you allergic to any metals? What? _____

Do you bleed excessively upon injury? _____

Are you pregnant? _____

Have you ever been involved with dental/medical legal action?

Do you use tobacco?

CIRCLE ANY OF THE FOLLOWING CONDITONS THAT YOU HAVE HAD OR NOW HAVE

AIDS/HIV Positive
Alzheimer's Disease
Anaphylaxis
Anemia
Angina
Arthritis/Gout
Artificial Heart Valve
Artificial Joint
Asthma
Blood Disease
Blood Transfusion
Breathing Problem
Bruise Easily
Cancer
Chemotherapy
Chest Pains
Cold Sores/Fever Blisters
Congenital Heart Disorder
Convulsions
Cortisone Medicine
Diabetes
Drug Addiction
Easily Winded
Emphysema
Epilepsy or Seizures
Excessive Bleeding
Excessive Thirst
Fainting. Dizziness
Frequent Cough
Frequent Diarrhea
Frequent Headaches
Genital Herpes
Glaucoma
Hay Fever
Heart Attack/Failure
Heart Murmur
Heart Pacemaker
Heart Trouble/Disease
Hemophilia
Hepatitis A
Hepatitis B or C
Herpes
High Blood Pressure
High Cholesterol
Hives or Rash
Hypoglycemia
Irregular Heartbeat
Kidney Problems
Leukemia
Liver Disease
Low Blood Pressure
Lung Disease
Mitral Valve Prolapse
Osteoporosis
Pain in Jaw Joints
Parathyroid Disease
Psychiatric Care
Radiation Treatment
Recent Weight Loss
Renal Dialysis
Rheumatic Fever
Rheumatism
Scarlet Fever
Shingles
Sickle Cell Disease
Sinus Trouble
Spina Bifida
Stomach/Intestinal Disease
Stroke
Swelling of Limbs
Thyroid Disease
Tonsillitis
Tuberculosis
Tumors or Growths
Ulcers
Venereal Disease
Yellow Jaundice

PERSON TO BE CONTACTED INCASE OF EMERGENCY (OTHER THAN RELATIVE)

Name: _____

Address: _____

Telephone: (Home) _____(Work) _____(Cell) _____

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or Patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE: _____

REVIEWED BY: _____ DATE: _____