**PATIENT INFORMATION FORM** **DANSVILLE DENTAL PROFESSIONALS, LLP**

NAME:_____MARRIED __SINGLE __MALE __FEMALE
Last First Middle

ADDRESS:_____
Street City State Zip Code

BIRTHDATE:_____ TELEPHONE: ( )_____ ( )_____
Home Work

PLACE OF EMPLOYMENT (Or School) _____SSN:_____
DENTAL INSURANCE CO.:_____ GROUP #:_____
HAS ANY MEMBER OF YOUR FAMILY EVER BEEN TREATED IN OUR OFFICE? _____YES_____NO
HOW DID YOU HEAR ABOUT OUR PRACTICE? _____

**FAMILY INFORMATION**

| | FATHER (or Husband) | MOTHER (or Wife) |
|---|---|---|
| NAME: | _____ | _____ |
| ADDRESS: | _____ | _____ |
| | Street City State Zip | Street City State Zip |
| BIRTHDATE/SSN: | _____ | _____ |
| EMPLOYER: | _____ | _____ |
| DENTAL INSURANCE CO.: | _____ | _____ |
| | NAME GROUP# | NAME GROUP# |

**MEDICAL INFORMATION**

PHYSICIAN: (Name/Phone#)_____
PREVIOUS DENTIST: (Name/Phone#)_____
LIST ALL MEDICATIONS YOU ARE PRESENTLY TAKING:_____
_____
IN CASE OF EMERGENCY, PLEASE CALL: _____
(NAME/PHONE# OF NEAREST RELATIVE NOT LIVING IN HOUSEHOLD)
LIST ALL ALLERGIES:_____
HAVE YOU EVER BEEN HOSPITALIZED? _____YES_____NO WHY/WHEN: _____
_____ ARE YOU PREGNANT?_____YES_____NO

| DO YOU HAVE/HAVE YOU EVER HAD | YES/NO | | YES/NO |
|---|---|---|---|
| Heart Murmur / Mitral Valve Prolapse | ___ ___ | Chronic Headaches | ___ ___ |
| Heart Disease / Congenital Lesions | ___ ___ | Cancer / Radiation Treatments | ___ ___ |
| Hepatitis | ___ ___ | Lung Disease / Tuberculosis | ___ ___ |
| Arthritis | ___ ___ | Prolonged Bleeding / Anemia | ___ ___ |
| Abnormal Blood Pressure | ___ ___ | Epilepsy | ___ ___ |
| Diabetes | ___ ___ | Pacemaker | ___ ___ |
| Asthma / Sinus Trouble | ___ ___ | Rheumatic Fever | ___ ___ |
| Glaucoma / Eye Disorder | ___ ___ | Ulcers / Stomach Problems | ___ ___ |
| Jaundice / Kidney Problems | ___ ___ | Hip / Joint Replacement | ___ ___ |
| Pin / Screw Placement | ___ ___ | HIV Positive | ___ ___ |
| Jaw Pain / TMJ Syndrome | ___ ___ | Take Aspirin Daily | ___ ___ |

PLEASE LIST ANY OTHER CONDITION, TREATMENT OR SURGERY NOT MENTIONED ABOVE:
_____

**AUTHORIZATION**

I hereby authorize payment directly to the dental office of the insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I understand a monthly billing fee will be added to any balance over thirty days and any portion of said bill not paid will be turned over to a collection agency and I am responsible for the collection fees. I authorize the release of my dental/medical records and treatment information to my insurance company, doctors, and care givers. I have received a copy of the Notice of Privacy Practices and I give my consent to the use and disclosure of my personal heath information to carry out treatment, payment activities, and healthcare operations. (You may revoke this consent at any time by giving written notice. We may decline to treat you or continue treatment if you revoke this consent.) I authorize DDP to mail to me practice information, appointment notices, treatment information, or dental educational materials. The information on this page, including the medical history, is correct and complete.

DATE: _____ SIGNATURE: _____

Self___ Father___ Mother___ Guardian_____ Other___(Relationship)_____