

Patient Information Form

In order to serve you properly, we need the following information. All information is strictly confidential.

(Please print clearly)

Referred by _____ Preferred appt. time & day _____

Patient's Name _____ Birthdate _____
(Last) (First) (Middle)

Social Security # _____ - _____ - _____ Marital Status _____ Gender M _____ F _____

Address _____ City _____ Zip Code _____

Home Phone () _____ Cell () _____ Email _____

Occupation _____ If student, name of school _____

Employer _____ Work phone () _____ Ext. _____

Address _____ City _____ State _____ Zip Code _____

Name of spouse (or parent) _____ Address _____

Social Security # of spouse (or parent) _____ - _____ - _____ Phone () _____

In case of emergency- Name of nearest relative or friend _____

Address _____ Zip Code _____ Phone () _____

Chief complaint / Reason for visit _____

List any allergies you have (drugs, food, pollen, animals, etc.) _____

LATEX ALLERGY? Yes / No Sensitivity to the powder in latex gloves? Yes / No Notes: _____

List any medications you are taking _____

Have you taken diet pills containing "fen-phen", fenfluramine (Pondimin), dexfenfluramine (Redux)? Yes / No

Describe any conditions we should know about _____

High cholesterol? Yes / No Diabetes? Yes / No Bad reaction to local anesthetics? Yes / No

Primary insurance company _____ Policy # _____

Insured name _____ Social Security # _____ - _____ - _____

Do you have insurance through your employer? _____ If yes, I.D. # _____

Group # _____

Secondary insurance company _____ Policy # _____

Insured name _____ SSN _____ - _____ - _____ Date of birth _____

I understand that I am financially responsible for all charges and services to me, including the balance remaining after payment of possible insurance benefits.

Signed _____ Date _____
(patient, or parent/legal guardian if under 18)

Assignment of benefits

I authorize payment of dental benefits to Stephen M. Lee, DDS or Diana C. Fong, DDS for professional services rendered.

Signed _____ Date _____
(patient, or parent/legal guardian if under 18)

Release of information

I authorize the release of any medical information necessary to process this claim.

Signed _____ Date _____
(patient, or parent/legal guardian if under 18)

GENERAL

MEDICAL

INSURANCE

FINANCIAL