PATIENT INFORMATION

PRINT PATIENT NAME

Last **First** **MI**

Name to be called: _____

_____Male _____ Female

Marital Status: __Married __Single __Divorce

__Widowed

Date of Birth: SS# or INS ID:

DATE

PRIMARY DENTAL INSURANCE

Insurance Company:

Address:

Insurance Telephone Number:

Home Address:

Insurance ID Number:

Insurance Group Number:

Home Telephone Number

Work Telephone Number Ex:
(Can you be called at work?)

Cell Telephone Number

Email Address:

Name of Insured:

Relation:

Date of Birth: SS#:

Employer:

Address:

Who is your
General Dentist?

Name of Spouse:

Date of Birth:

SS#: (if using spouse's insurance)

Employer:

Employer Telephone Number:

SECONDARY DENTAL INSURANCE

Insurance Company:

Address:

Insurance ID Number:

Insurance Group Number:

Name of Insured:

Relation:

Date of Birth: SS#:

ACCOUNT RESPONSIBILITY

Name: SS#

Relationship:

Billing Address:

IN CASE OF EMERGENCY:

Contact Person:

Cell Telephone:

Home Telephone:

Work Telephone:

COMPLETE BOTH SIDES OF FORM. THANK YOU.

COMPLETE BOTH SIDES OF FORM. THANK YOU.

MEDICAL HISTORY

PATIENT NAME_____

The below information is necessary to properly correspond with other offices.

Medical doctor's name (**Please give first and last name**) _____

Medical Doctor's Address:

Medical Doctor's Telephone:

Are you under a doctor's care now? Yes ____ No ____ Why?

Female Patients: Are you pregnant? Yes____ No ____

Are you taking any medications, pills, or drugs? What?

(PLEASE INCLUDE OVER THE COUNTER MEDICATION - USE SEPARATE SHEET OF PAPER, IF NECESSARY)

Are you a smoker? YES_____ NO_____ How many packs per day? _____

Do you have a medical condition or a physician that requires you to be pre-medicated (take antibiotics) prior to dental procedures? YES____ NO____

If so, what medication _____ Why _____

Are you allergic to any medications or substance? See Below

Aspirin	Penicillin	Sulfa	Codeine	Morphine	Steroids	Erythromycin	Tetracycline	Dental Anesthetics	Latex
Other									

Please CIRCLE if you have/had any of the following!

Aids (HIV pos)	Allergies	Alzheimer's Disease	Anemia	Blood Transfusion
Artificial Heart Valve	Artificial Joints / Hips	Asthma	Blood Disease	Emphysema
Easily Bruise	Cancer	Chest Pain	Chemotherapy / Radiation	Herpes
Cortisone Injection	Congenital Heart Lesion	Diabetes	Drug Addiction	Excessive Thirst
Epilepsy or Seizures	Heart Murmur	Hepatitis A,B, C	Hemophilia	Respiratory Problems
Hypoglycemia	Liver Disease	Psychiatric Care	High Blood Pressure	Heart Surgery
Glaucoma	Rheumatic Fever	Kidney Problems	Thyroid Problems	X-Ray Treatment
Venereal Disease	Stroke/ TIA	Rheumatism	Heart Trouble	TB (Tuberculosis)
Pain in Jaw Joints	Low Blood Pressure	Mitral Valve Prolapse	Fever Blisters/Cold Sores	
Pacemaker	Parkinson's Disease	Other		

Have you ever had a serious illness not circled above? Describe

Additional Comments:

_____

Patient Signature (Parent or Guardian) Date

Reviewed by: _____

Staff Signature

GREGG W. MCKENZIE, D.D.S.
124 Alpine Circle, Columbia, SC 29223
(803) 788-0900
FAX 788-0637