

PATIENT INFORMATION

Date _____ Yearly Update _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Email _____

Date of Birth _____ Social Security No. _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name _____ Relationship to Patient _____
Last First Middle

Father's Name _____ Marital Status _____
Last First Middle

Mailing Address _____
Street City State Zip

How long at this address? _____ Email _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security No. _____ Birthdate _____ Employer _____

Mother's Name _____ Marital Status _____
Last First Middle

Mailing Address _____
Street City State Zip

How long at this address? _____ Email _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security No. _____ Birthdate _____ Employer _____

I understand and agree that regardless of my insurance coverage, I am ultimately responsible for the balance on this account for any professional services rendered. I also understand that credit reports may be obtained. I certify this information is true and correct to the best of my knowledge.

Signature _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____
Street City State Zip

Home Phone _____ Cell Phone _____

PLEASE COMPLETE MEDICAL HISTORY AND INSURANCE INFORMATION ON REVERSE SIDE

PATIENT MEDICAL HISTORY INFORMATION

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Are you in good health at this time? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you been under a physician's care in the past three years? | <input type="checkbox"/> | <input type="checkbox"/> |
| Physician _____ Reason _____ | | |
| 3. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has surgery ever been advised? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you allergic to any drugs or medications? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, please list _____ | | |
| 6. Do you have any latex or environmental allergies? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, please list _____ | | |
| 7. Are you taking any medications at the present time? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, please list _____ | | |
| 8. Have you ever had any of the following? <i>(Please Circle)</i> | | |
| Hepatitis Heart Trouble Asthma Jaundice Diabetes Rheumatic Fever | | |
| Cancer Liver Disease Kidney Disease Blood Disease Leukemia | | |
| Herpes H.I.V. (AIDS) High Blood Pressure Heart Murmur Scarlet Fever | | |
| Epilepsy (seizures) Fainting Spells Prolonged Bleeding | | |
| 9. Have you ever received antibiotic premedication for routine dental visits? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, for what reason? _____ | | |
| 10. Do you have any medical condition not listed above? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, please list _____ | | |
| 11. Family Physician _____ | | |
| 12. Family Dentist _____ | | |

This information given by _____ updates (date + initial) _____

DENTAL INSURANCE INFORMATION

Subscriber's Name _____ Subscriber's Social Security No. _____

Subscriber's Birthdate _____ Relationship to Patient _____

Insurance Company _____ Group No. _____ I.D. No. _____

Insurance Co. Address _____

Insurance Co. Phone # _____

Is the patient a full time college student? Yes _____ No _____

IS THE PATIENT COVERED BY ANY OTHER DENTAL PLAN? _____ IF YES:

Subscriber's Name _____ Subscriber's Social Security No. _____

Subscriber's Birthdate _____ Relationship to Patient _____

Insurance Company _____ Group No. _____ I.D. No. _____

Insurance Co. Address _____

Insurance Co. Phone # _____

I hereby authorize payment of the dental benefits otherwise payable to me to the office of Dr. McCaskey.

Signature _____