ADULT 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. _____

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

RESPONSIBLE PARTY INFORMATION

Responsible Party Name _____ Relationship to Patient _____
Last First Middle

Patient's Name _____ _____
Last First Middle Marital Status

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 _____

Spouse's Name _____ _____
Last First Middle Marital Status

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?	☐	☐
2. Have you been under a physician's care in the past three years?	☐	☐
Physician _____ Reason _____		
3. Have you ever had surgery?	☐	☐
4. Has surgery ever been advised?	☐	☐
5. Are you allergic to any drugs or medications?	☐	☐
If so, please list _____		
6. Do you have any latex or environmental allergies?	☐	☐
If so, please list _____		
7. Are you taking any medications at the present time?	☐	☐
If so, please list _____		

8. Have you ever had any of the following? *(Please Circle)*

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?	☐	☐
10. Do you have any medical condition not listed above?	☐	☐
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. _____

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. _____

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 _____