Sisson Family Dentistry Information Sheet

Patient Information

Last Name _____ First Name _____ MI _____
Name preferred to be called _____
Date of Birth _____ Sex - M F

Address _____ City, State, Zip _____
Employer _____ Occupation _____
Social Security # _____ Driver's License # _____

Home Phone (____) _____ Work Phone (____) _____
Cell Phone (____) _____ E-Mail _____
Marital Status M S D W O _____ Spouse's Name _____
In case of Emergency Contact _____
How did you hear about our Office? _____

Responsible party information

Name of Person Responsible for this Account _____
Relationship to Patient _____ Employer _____
Insurance Company _____ Group # _____
Insurance Co Phone # _____
Home Address (if different) _____ City, State, Zip _____
Home Phone (____) _____ Work Phone (____) _____
Cell Phone (____) _____
Social Security # _____ Date of Birth _____

Medical History

Physician's Name _____ Telephone _____
Women: Are you Pregnant/Nursing? Y N Due Date _____

Please Circle Yes or No for the following conditions:

Y N Heart Problems
Y N HIV/Aids
Y N Artificial Bones/Joints
Y N Hepatitis
Y N Diabetes
Y N Breathing Difficulty
Y N Ulcers/Colitis
Y N Abnormal Bleeding with Extractions or Surgery
Y N Heart Murmur
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Rheumatic Fever
Y N Sinus Problems
Y N Asthma
Y N Kidney Problems
Y N Epilepsy
Y N Glaucoma
Y N High/Low Blood Pressure
Y N Artificial Heart Valves
Y N Heart Attack/Stroke - Date _____
Y N Cancer/Radiation Treatment
Y N Drug/Alcohol Dependency
Y N Emphysema/Respiratory Disease
Y N Liver Problems
Y N Psychiatric/Nervous Problems
Y N Thyroid Problems

Allergies

Y N Penicillin
Y N Codeine
Y N Other _____
Y N Sulfa
Y N Aspirin
Y N Latex
Y N Anesthetic

Is there any other pertinent Medical Information that we need to know? _____
Has a Physician ever stated that you need Antibiotic Pre-medication before dental work Y N
List any Medications you are Presently taking _____
Pharmacy _____ Phone (____) _____

The information on this form is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of Insurance Benefits. I agree to pay for all professional fees and treatments not covered by my dental insurance. I realize that Sisson Family Dentistry will file my Insurance Claim as courtesy and that I am responsible for full payment of fees not paid by my Insurance company within 60 days from the date of service. I further agree to pay any collection fees, attorney fees, and court costs should these means of collection become required. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____ Relationship _____