

Readington Dental

Patient Information Form

1. Patient Information

- **Name:** (Last) _____ (First) _____ (Initial) _____
- **Address:** _____
- **City:** _____ **State:** _____ **Zip:** _____
- **Home Phone:** _____ **Cell Phone:** _____
- **Email:** _____
- **Birthdate:** _____ **Age:** _____ **Sex:** M F
- **Status:** Single Married Widowed Separated Divorced
- **Patient Employed By:** _____ **Occupation:** _____
- **Business Address:** _____
- **Business Phone:** _____ **Business Email:** _____
- **Whom may we thank for referring you?** _____

2. Emergency Contact

- **Name:** _____ **Home Phone:** _____
- **Cell Phone:** _____ **Business Phone:** _____
- **Email:** _____

3. Insurance Information

Primary Insurance

- **Insurance Company:** _____ **Phone:** _____
- **Subscriber Name:** _____
- **Birthdate:** _____ **Relation to Patient:** _____
- **Contract #:** _____ **Group #:** _____
- **Subscriber #:** _____

Additional Insurance

- **Is patient covered by additional insurance?** Yes No
 - **Insurance Company:** _____ **Subscriber Name:** _____
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4. Dental History

- **What would you like us to do today?** _____
 - **Are you in dental discomfort today?** _____
 - **Former Dentist:** _____ **Date of last dental care:** _____
 - **How often do you brush?** _____ **How often do you floss?** _____
 - **Check (✓) if you have had problems with any of the following:**
 - Bad breath | Bleeding gums | Grinding/Clenching teeth
 - Sensitivity to Hot/Cold/Sweets | Clicking/Popping jaw
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5. Medical History

- **Physician's Name:** _____ **Phone:** _____
 - **Are you currently under physician care?** Yes No
 - **Have you had any serious illnesses or operations?** Yes No
 - **Women: Are you pregnant?** Yes No | **Nursing?** Yes No
 - **Check (✓) if you have/had any of the following:**
 - AIDS/HIV | Arthritis | Asthma | Cancer
 - Diabetes | Epilepsy | Heart Problems | Hepatitis
 - High Blood Pressure | Tobacco Habit
 - **List all current medications:** _____
 - **List all drug allergies:** _____
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6. Authorization

I certify that the information on this questionnaire is accurate to the best of my knowledge. I understand this information will be used to determine appropriate dental treatment. I authorize the insurance company to pay the dentist directly and understand I am financially responsible for all charges whether or not paid by insurance. Payment is due in full at time of treatment unless prior arrangements have been approved.

Signature: _____ **Date:** _____