MAD RIVER
FAMILY DENTAL

PATIENT INFORMATION

Patient Name:____ Date:__________________
Last First MI

Preferred Name:__________________________________ Gender: Male ☐ Female ☐

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Social Security#____________________________ Birthdate ______/______/______

Address ____

City _________________________________ State __________________ Zip __________

Home Phone ________________ Cell Phone ________________ Work Phone ________________

Which is best to reach you at? ___________________

SPOUSE OR RESPONSIBLE PARTY

Name:____ Gender: Male ☐ Female ☐
Last First MI

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Social Security#____________________________ Birthdate ______/______/______

Address ____

City _________________________________ State __________________ Zip __________

Home Phone ________________ Cell Phone ________________ Work Phone ________________

Which is best to reach you at? ___________________

INSURANCE INFORMATION

Primary Insurance

Subscriber's Name:____
Last First MI

Insured's Birthdate ______/______/______ ID#________________ Group#________________

Employer's Name:______________________ Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name & Address:____

Insurance Plan Phone # ______________________

Secondary Insurance

Subscriber's Name:____
Last First MI

Insured's Birthdate ______/______/______ ID#________________ Group#________________

Employer's Name:______________________ Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name & Address:____

Insurance Plan Phone # ______________________

MAD RIVER
FAMILY DENTAL

HEALTH HISTORY

Major Operations or Hospitalizations:____________________

Please list any **MEDICATIONS** you are taking:____________________

____

____

Are you allergic to any of the following:

☐ Aspirin ☐ Metal ☐ Penicillin ☐ Latex ☐ Codeine ☐ Sulfa Drugs ☐ Acrylic ☐ Local Anesthetics

Other Allergies (Including Food Allergies):____________________

Have you been diagnosed with Sleep Apnea? If yes, do you wear an appliance?____________________

PLEASE MARK IF YOU HAVE OR HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS:

☐ AIDS/HIV POSITIVE
☐ ALZHEIMER'S
☐ ANAPHYLAXIS
☐ ANEMIA
☐ ANGINA
☐ ARTHRITIS/GOUT
☐ ARTIFICIAL HEART VALVE
☐ ARTIFICIAL JOINT
☐ ASTHMA
☐ BLOOD DISEASE
☐ BLOOD TRANSFUSION
☐ BREATHING PROBLEMS
☐ BRUISE EASILY
☐ CANCER
☐ CHEMOTHERAPY/RADIATION
☐ COLD SORES/FEVER BLISTERS
☐ CONGENITAL HEART DISORDERS
☐ CORTISONE
☐ DIABETES
☐ DRUG ADDICTION
☐ EMPHYSEMA
☐ EPILEPSY/SEIZURES
☐ EXCESSIVE BLEEDING
☐ EXCESSIVE THIRST
☐ FAINTING SPELLS/DIZZINESS
☐ FREQUENT COUGH
☐ FREQUENT HEADACHES
☐ GLAUCOMA
☐ HEAD/NECK INJURIES
☐ HEART ATTACK/FAILURE
☐ HEART MURMUR
☐ HEART PACEMAKER
☐ HEART TROUBLE/DISEASE
☐ HEMOPHILIA
☐ HERPES
☐ HIGH BLOOD PRESSURE
☐ HIGH CHOLESTEROL
☐ HIVES OR RASH
☐ HYPOGLYCEMIA
☐ IRREGULAR HEARTBEAT
☐ KIDNEY PROBLEMS
☐ LEUKEMIA
☐ LIVER DISEASE
☐ LOW BLOOD PRESSURE
☐ LUNG DISEASE
☐ LYMES DISEASE
☐ LUPUS
☐ MITRAL VALVE PROLAPSE
☐ RHEUMATIC FEVER
☐ RHEUMATISM
☐ SCARLET FEVER
☐ SHINGLES
☐ SICKLE CELL DISEASE
☐ SINUS TROUBLE
☐ SPECIAL DIET
☐ SPINA BIFIDA
☐ STOMACH/INTESTINAL DISEASE
☐ STROKE
☐ THYROID DISEASE
☐ TOBACCO USE
☐ TONSILLITIS

Name of Physician:____________________ **Pharmacy:**____________________

Print Name:____________________ **Signature:**____________________

Relationship to Patient:____________________ **Date:**____________________