

## PATIENT INFORMATION

Date \_\_\_\_\_

SSN/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name

\_\_\_\_\_ First Name Middle Initial

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_

Birthdate \_\_\_\_\_

Married  Widowed  Single  
 Divorced  Minor  Separated

Patient's Employer/School \_\_\_\_\_

Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone ( ) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SSN \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## DENTAL INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance CO. \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_ Group # \_\_\_\_\_

\*Is patient covered by additional insurance? \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SSN \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_ Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with

\_\_\_\_\_  
Name of Insurance Company (ies)

I understand that I am financially responsible for all charges incurred by myself and/or my family under this account whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named dentist may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable related services. This consent will end when I end my dental relationship with Daniel P. Kelliher, D.D.S.

\_\_\_\_\_  
Signature of Patient/Parent/Guardian

\_\_\_\_\_  
Date  
Print Name of Patient/Parent/Guardian

## PHONE NUMBERS

Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Ext \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Spouse's Work ( ) \_\_\_\_\_ Best time to reach you \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household.)

Name \_\_\_\_\_ Relationship \_\_\_\_\_



MEDICATIONS	ALLERGIES																														
List any medications you are currently taking and the correlating diagnosis: _____ _____ _____ Pharmacy Name _____ Phone Number _____	Circle all that apply: <table> <tr> <td>Aspirin</td> <td>Yes</td> <td>No</td> <td>Local Anesthetic</td> <td>Yes</td> <td>No</td> </tr> <tr> <td>Barbiturates (Sleeping Pills)</td> <td>Yes</td> <td>No</td> <td>Penicillin</td> <td>Yes</td> <td>No</td> </tr> <tr> <td>Codeine</td> <td>Yes</td> <td>No</td> <td>Sulfa</td> <td>Yes</td> <td>No</td> </tr> <tr> <td>Iodine</td> <td>Yes</td> <td>No</td> <td>Other _____</td> <td></td> <td></td> </tr> <tr> <td>Latex</td> <td>Yes</td> <td>No</td> <td></td> <td></td> <td></td> </tr> </table>	Aspirin	Yes	No	Local Anesthetic	Yes	No	Barbiturates (Sleeping Pills)	Yes	No	Penicillin	Yes	No	Codeine	Yes	No	Sulfa	Yes	No	Iodine	Yes	No	Other _____			Latex	Yes	No			
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Latex	Yes	No																													

UPDATES (To be filled in at future appointments)	
Has there been an change in your health since your last dental appointment?	Yes No
For what conditions? _____	
Are you taking any new medications? Yes No	If so, what is the name of the medication _____
Has there been a change in your contact information?	Yes No
If so, please list changes: Address _____ Phone # _____	
Has there been a change in your dental insurance information?	Yes No (Please provide you card to the front desk to make any changes.)
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