David R. Deitrick D.D.S., P.A.

Family Dentistry

PATIENT INFORMATION

Patient's Name: _____ Date: _____
Street Address: _____
City/State: _____ Zip Code:_____
Home Phone #:_____ Cell Phone #: _____ Work Phone #: _____
Date of Birth: _____ S.S #: _____Gender: ____ Email Address: _____
Employer: _____ Spouse's Name: _____
If patient is a full-time student, Name of School/City/State: _____
Children's Names & Ages: _____
Family Physician Name: _____Phone #: _____
Whom may we thank for referring you? _____

PRIMARY INSURANCE

Policy Holder: _____ Relation to Patient: _____
Address (if different than patient): _____
Policy Holder's Employer: _____ Date of Birth: _____ SS#: _____
Insurance Company_____ Group #: _____
Subscriber ID#: _____ Insurance Company Phone #: _____
Insurance Company Address: _____
City/State/Zip Code: _____
Do you have additional (**Secondary**) Insurance? If yes, please list the Secondary Insurance Information, Name, Address, Phone #, Group #, Subscriber ID #:_____
_____

HEALTH HISTORY

Current Medications/Dosages:_____
_____
Allergies (List): _____ Serious Illnesses List):_____
_____ _____
Hospitalizations (Date/Reason): _____
_____
_____
Do You Smoke? _____ Do You Consume Alcohol? _____

Please check if you have had any of the following:

__Headaches	__Tuberculosis	__Diabetes	__Kidney Disease
__Head Injury	__Asthma	__Thyroid Problems	__Sinus Problems
__Lung Disease	__Other Gland Problems	__Cancer	__Cancer
__Frequent Nose Bleeds	__Heart Attack	__Steroid Treatment	__Bleeding Problems
__Frequent Sore Throat	__Chest Pains	__Seizures-Convulsions	__AIDS
__Other Throat Problems	__Heart Murmur	__Stroke	__STD's
__Jaundice	__Rheumatic Fever	__Fainting	__X-Ray Treatments
__Hepatitis	__Other Heart Disease	__Emotional Problems	
__Liver Disease	__Abnormal Blood Pressure	__Bone Problems	
__Other Blood Vessel Disease	__Anemia	__Tumor	

PLEASE LIST ANY OTHER HEALTH PROBLEMS OR ADDITIONAL INFORMATION ON THE REVERSE SIDE.

DATE: _____ **SIGNATURE: _____**