



ROCKY MTN ENDO | PATIENT INFORMATION

PATIENT INTRODUCTION

-PLEASE PRINT-

PATIENT'S FIRST NAME	MIDDLE NAME	LAST NAME	REFERRING DENTIST
SOCIAL SECURITY #	DATE OF BIRTH	SEX	MARITAL STATUS
HOME PHONE #	CELL PHONE #	TEXT MESSAGING	
EMAIL ADDRESS	STREET ADDRESS	APT. #	CITY
		STATE	ZIP CODE
PATIENT'S OCCUPATION	PATIENTS EMPLOYER	SPOUSE'S NAME	SPOUSE'S EMPLOYER
WORK PHONE #	WORK EMAIL	SPOUSE'S WORK #	SPOUSE'S EMAIL

WERE YOU REFERRED BY
 GENERAL DENTIST FRIEND OR FAMILY _____ NAME _____
 YOUR DENTAL INSURANCE INTERNET

RESPONSIBLE PARTY

-PLEASE COMPLETE THIS SECTION BELOW IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE-

FIRST NAME	MIDDLE NAME	LAST NAME	HOME PHONE
STREET ADDRESS	APT. #	CITY	STATE
		ZIP CODE	
RELATIONSHIP TO PATIENT	EMPLOYER	WORK PHONE #	EMAIL ADDRESS

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	INSURANCE ADDRESS		
POLICY HOLDER (SUBSCRIBER)	BIRTHDATE	ID #	GROUP #
SECONDARY INSURANCE COMPANY	INSURANCE ADDRESS		
POLICY HOLDER (SUBSCRIBER)	BIRTHDATE	ID #	GROUP #

SPECIAL REQUESTS

I have been given the opportunity to ask any questions and have received answers to my satisfaction _____ INITIAL _____ DATE



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HEALTH INFORMATION

-THE FOLLOWING CONFIDENTIAL INFORMATION IS FOR OUR RECORDS ONLY-

• Family Physician | _____ | _____ | _____ | _____
FIRST NAME LAST NAME OFFICE # CITY

- In good health | YES | NO
- Currently under medical care | YES | NO
- Hospitalized within the past 2 years | YES | NO

IF YES, FOR WHAT REASON

• Currently taking any medications | YES | NO

IF YES, LIST MEDICATIONS

• Allergic to any drugs | YES | NO

IF YES, LIST MEDICATIONS

- Allergic to latex | YES | NO
- Unfavorable reaction to a dental treatment | YES | NO
- Do you pre-medicate prior to treatment | YES | NO

IF YES, THEN WHY?

CIRCLE ANY OF THE FOLLWING WHICH YOU HAVE HAD:

-THE FOLLOWING CONFIDENTIAL INFORMATION IS FOR OUR RECORDS ONLY-

- | | | |
|---------------------|-----------------------|--------------------|
| • Arthritis | • Heart Problems | • Phen-Fen Diet |
| • Asthma | • Hepatitis | • Rheumatic Fever |
| • Bleeding Problems | • Herpes | • Stroke |
| • Cancer | • High Blood Pressure | • Tuberculosis |
| • Diabetes | • H.I.V + | • Jaundice |
| • Epilepsy | • Kidney Problems | • Venereal Disease |
| • Heart Murmur | • Low Blood Pressure | • Other |

Female Patients: Are you Pregnant? _____ Which Month? _____

SPECIAL INFORMATION

I have been given the opportunity to ask any questions and have received answers to my satisfaction | _____ | _____
INITIAL DATE