## PATIENT

First (Legal) Name: ________________ Middle Initial: ____ Last Name: ________________ Nickname: ______

Male / Female Marital Status: ____ Date of Birth: _________ Age:____ SS#: ____________________________

Address: ________________________________________ Primary #: __________________Home:__Cell:__

City: ____________________ State: _____ Zip:__________ Alternate #: __________________Home:__Cell:__

Patient Email: __________________________________ School Name: ______________________________

Parent Email: ____________________________________________________________________________

Reason for this appointment ? ______________________________________________________________

Is the reason for your appointment the result of an accident or injury? Yes ____ No _____

Source of Referral (specify): Doctor: ______________ Online Review/Site: ___________ Friend: ____________

Name of General Dentist: _____________________________ Orthodontist: __________________________

Have you, a friend or a family member been seen/treated by Dr Patino? If so, who? ______________________

_____________________________________________________________________________________

## MEDICAL INFORMATION

Please list any **allergies to medications**? ____________________________________________________

Any problems with eggs, lecithin, soy or **latex**? _______________________________________________

Please list all medications you're currently taking: ______________________________________________

Hospitalizations, surgeries or ER visits (last 5 yrs): ______________________________________________

_____________________________________________________________________________________

Height ______ Weight______ Do you smoke?______ Amount per day?__________ How many years? ______

Are you under the care of a physician? _____ Reason? ____________________________________________

Primary Care Physician: ___________________________________ Phone #: _________________________

### Do you have any history of the following:

____ Asthma / Wheezing
____ Current use of Inhaler:Yes__No_
____ Shortness of Breath
____ Sinus Problems
____ Respiratory Disease / Bronchitis
____ Sleep Apnea (Use of CPAP:____)
___ Diabetes (Type: _______)
___ Epilepsy / Seizures / Fainting
___ Thyroid Problems
___ Headaches
___ Knee, Hip, Joint Replacement
___ Arthritis / Rheumatism
___ Hepatitis (Type: _______)

___ Liver Disease
___ Kidney Problems
___ Bleeding Problems / Hemophilia
___ Blood Disease
___ Low **or** High Blood Pressure
___ Taking Blood Thinners
___ Heart Murmur
___ Pacemaker / Stent
___ Heart Attack (Date:_________)
___ Stroke (Date:______________)
___ Cancer (Type: ____________)
___ Radiation / Chemotherapy (Date: ______________)

___ Tuberculosis (TB) (Diagn or Vaccine)
___ HPV (Diagnosis or Vaccine)
___ HIV / AIDS
___ Chemical Dependency
___ Currently Pregnant / Nursing
___ Wear Contacts
___ Psychiatric Condition (i.e., depression): (___________________________)
___ Cognitive Condition (i.e., ADHD): (___________________________)

**Other Medical Conditions**: No___ Yes: _______________________________________________________

Traveled outside of the US in the last 3 months? ___ Yes ___ No (If yes, please specify country _______________)

________________________________ ____________________________ _________________

Signature of Patient or Legal Guardian Print Full Name Date

## LEGAL GUARDIANSHIP (FOR MINORS ONLY-UNDER 18)

If you are not the patient's parent, do you have a Medical Power of Attorney or proof of legal guardianship with you today? ___Yes ___ No

***** *Please be advised that HMO medical plans do not provide coverage for out-of-network providers. Dr. Patino is considered out-of-network for all medical plans.***

## SUBSCRIBER FOR PRIMARY INSURANCE

**Legal Name**:______________________________ Relationship to Patient: ______________________

SS#: ______________________________ DOB: ____________ Marital Status: ___S___M___D

Address: ______________________________ Cell Phone: ______________________

City: ______________________________ State: _______ Zip: ______________________

Email: ________________________________________________________________

Employer: ______________________________ Work Phone: ______________________

**Primary Dental Insurance**:____________________ PPO( ) HMO( ) Plan ID: ______________________

Group: ______________________

**Primary Medical Insurance**:____________________ PPO( ) HMO( ) Plan ID:______________________

Group: ______________________

## SUBSCRIBER FOR SECONDARY INSURANCE

Legal Name: ______________________________ Relationship to Patient: ______________________

SS#: ______________________________ DOB: ____________ Marital Status: ______________

Address: ______________________________ Home Phone: ______________________

City: ______________________________ State: _______ Zip: ______________________

Email: ________________________________________________________________

Employer: ______________________________ Work Phone: ______________________

**Secondary Dental Insurance**:________________ PPO( ) HMO( ) Plan ID: ______________________

Group: ______________________

**Secondary Medical Insurance**:________________ PPO( ) HMO( ) Plan ID:______________________

Group: ______________________

## FINANCIALLY RESPONSIBLE PARTY

I understand and agree that, regardless of my insurance status, I am ultimately responsible for payment for any professional services rendered. I have read all the information on this form and certify it to be true and correct to the best of my knowledge. Additionally, I will notify you of any changes in my status (address, insurance coverage, marital status, etc).

Name of person responsible for payment: ________________________________________

______________________________ ______________________________ ______________

Signature of Patient or Legal Guardian Print Full Name Date