PRESTON KNIGHT, D.D.S.

PATIENT INFORMATION

Last Name _____First Name _____Initial_____
Nickname _____Male _____ Female _____ Birthdate _____Age _____
Home Address _____ City _____ State _____Zip _____
Home Phone _____Work Phone _____Cell Phone _____
Mailing Address _____SS# _____
Employer _____ Employer Address _____
Marital Status: _____Married _____Single _____Other_____

PERSON RESPONSIBLE FOR PAYMENT IF NOT YOURSELF

Name_____ Relationship to Patient_____
SS#_____ Telephone Number_____
Employer_____ WorkNumber_____
Address_____ Home Phone_____
Contact Name, Address & Phone Number_____

*Whom may we thank for referring you to our office:*_____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE:
Name of Insured_____ Date of Birth _____
Relationship to Insured _____ SS#_____
Insurance Company_____Telephone Number_____
Group Number_____ Policy Number_____

SECONDARY INSURANCE:
Name of Insured_____ Date of Birth _____
Relationship to Insured _____ SS# _____
Insurance Company _____ Telephone Number _____
Group Number _____ Policy Number _____

GENERAL INFORMATION

We are willing to help you receive the maximum benefits your dental program provides. Please provide us with a completed insurance form & card from your insurance company. Your dental benefit program is a contract between you & your employer and the insurance company. This office is not a party to this contract.

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR MY ACCOUNT.

Signature _____Date _____

HEALTH HISTORY

Name: _____
Medical Physician: _____

Are you under medical care at this time? ☐ No ☐ Yes Explain _____

_____

Have you ever been diagnosed with any of the following:

__ Endocrine Disease
__ Pacemaker
__ Sinus Trouble
__ Asthma
__ Epilepsy
__ Thyroid Disease
__ Tuberculosis
__ Hepatitis

__ Heart Disease
__ Heart Attack
__ Heart Murmur
__ Angina
__ Glaucoma
__ Kidney Disease
__ Lung Disease
__ Ulcers

__ Diabetes
__ AIDS
__ Bleeding Disorder
__ Emotional Disorder
__ Cortisone Treatment
__ Birth Control Pills
__ Hypertension
__ Venereal Disease

__ Cancer
__ Rheumatic Fever
__ Liver Disease
__ Stroke
__ Bisphosphanate Therapy(Fosamax, Boniva, Zometa)

Do you have any allergies to medication?_____
List any serious illnesses_____
Have you ever had hives or a rash?_____
Do you tend to bleed a long time?_____
Have you had heart trouble?_____
Have you ever had chest pains?_____
Have you ever been exposed to the HIV virus?_____
Do you have a blood disorder?_____
Have you ever had convulsions or seizures?_____
Do you have artificial joints?_____
Do you smoke?_____How much? _____
Do you drink alcohol?_____How much? _____
Do you have any medical problems not mentioned?_____
(Women) Are you pregnant at this time?_____How long? _____
Please list any drugs and the dosage you are taking presently
_____
_____
What are your dental concerns?_____

__ Bleeding gums __ Tooth shifting __ Clenching teeth __ Loose teeth __ Jaw pain
__ Recession __ Night grinding __ Swelling __ Mouth odors

Comments:
_____

As the above information changes it is my responsibility to notify this office.

Patient Signature: _____**Date**_____***Thank you!***

Date Update Initials

_____
_____
_____