Shelton DENTAL CENTER

Health History -Patient Information

Name_____
_____
Last First Middle

Address_____
_____

City_____State_____Zip_____Email_____
_____

Phone(_____)_____(_____)_____(_____)_____
_____
Home Cell Work

Social Security #_____ Birthday_____ Male❑ Female❑

Emergency
Contact_____relationship_____

How did you hear about us?_____

Primary Dental Insurance

Subscriber Name: _____ Relationship to Patient:
_____

Social Security Number: _____ DOB:
_____

Subscriber ID Number: _____ Group ID Number:
_____

Employer Name: _____ Insurance Co. Phone:
_____

Insurance Co. Name/Address:
_____

Secondary Dental Insurance

Subscriber Name: _____ Relationship to Patient:
_____

Social Security Number: _____ DOB:
_____

Subscriber ID Number: _____ Group ID Number: _____

Employer Name: _____ Insurance Co. Phone: _____

Insurance Co. Name/Address: _____

Medical Insurance

Subscriber Name: _____ Relationship to Patient: _____

Social Security Number: _____ DOB: _____

Subscribers Address: _____

Subscriber ID Number: _____ Group ID Number: _____

Employer Name: _____ Insurance Co. Phone: _____

Employer Address: _____

Insurance Co. Name/Address: _____

Medical History

Conditions:

❑Abnormal bleeding
❑Alcohol or Drug Abuse
❑Aids/HIV
❑Allergies
❑Anemia
❑Angina
❑Asthma
❑Blood transfusions
❑Cancer/chemotherapy
❑Diabetes
❑Difficulty Breathing
❑Emphysema
❑Epilepsy
❑Fever Blisters/Herpes
❑Heart Attack

Date_____

❑Heart Murmur/Defect
❑Heart Surgery
❑Hemophilia/bleeding
❑Hepatitis Type_____

❑Blood Pressure: hi/low
❑Joint Replacement:

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Date_____

❑Kidney Problems
❑Liver Disease
❑Pacemaker
❑Psychiatric Disease
❑Radiation therapy
❑Rheumatic Fever
❑Seizures
❑STD
❑Shingles
❑Sickle Cell Disease
❑Sinus Problems
❑Stroke
❑Thyroid problems
❑Tuberculosis
❑Ulcers
❑Other_____
___

Allergies to:

❑Aspirin
❑Codeine
❑Anesthetics
❑Latex
❑Metals/Jewelry/Nickel
❑Penicillin
❑Sulfa
❑Tetracycline
❑Other_____
___

Miscellaneous:

Do you smoke?
yes❑ no❑
Do you chew?
yes❑ no❑

If Female:

Are you taking Birth Control Pills?
yes❑ no❑
Are you Pregnant?
yes❑ no❑

Medications and Dosage:

_____

_____

_____

Name of Current Physician: Phone Number:

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance carriers and assign directly to Shelton Dental Center, all insurance benefits, if any, otherwise payable directly to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize my dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. The information on this page and the medical history are correct to the best of my knowledge.

Responsible Party_____ Relation to patient_____

Signature_____ Date_____

Shelton DENTAL CENTER
1829 Jefferson Street - Shelton, WA 98584
Office 360-426-8401 - Fax 360-426-1427
Sheltondentalcenter@gmail.com

Records Release Form

I, (name) _____ request that my most current records be transferred to my new dental office.

From: _____ (dental office name)
_____ (dental office phone #)
_____ (dental office email)

To: _____ (dental office name)
_____ (dental office phone #)
_____ (dental office fax)
_____ (dental office email)

__ This request is just for me
__ This request is for myself and my family members (please list additional patients below):

_____
_____
_____
_____
_____

Signed:

_____ _____
Patient or guardian Date