Nash Dental Care – 951-699-0700

www.nashdentalcare.com

ABOUT YOU

All information required.

Today's Date _____

Name _____

I prefer to be called _____M____F_____

Birthdate ___/___/_____ SS# _____

Driver's License # _____

Home Address _____

City_____Zip_____

E-Mail Address _____

Single Married Divorced Widowed

Circle yes or no please:

Facebook: Yes / No Twitter: Yes / No

MySpace: Yes / No Text Messaging: Yes / No

Home # (____)_____ Cell # (___)_____

Work # (____)_____ Ext.____

Other # (____)_____

Employer _____

Employer's Address _____

How long there? _____ Occupation _____

Where and when are the best times to reach you?

_____

How did you hear about our office?

_____

SPOUSE INFORMATION

His/Her Name _____

Employer _____

Work # (____) _____ Cell#(___)_____

SS# _____

Birthdate ___/___/_____ CDL# _____

ABOUT PATIENT (MINOR)

All information required.

Today's Date _____

Name _____

I prefer to be called _____M____F_____

Birthdate ___/___/_____ SS# _____

Home Address _____

City_____Zip_____

PERSON RESPONSIBLE FOR ACCOUNT

Name _____

Billing Address _____

_____

Relationship to Patient _____

SS# _____ CDL# _____

Employer _____

Work # (____)_____ Cell# (____)_____

INSURANCE COVERAGE

Primary

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # (____)_____

Group or Plan # _____

Insured's Name _____

Relationship to Patient _____

Insured's Birthdate ___/___/_____ SS# _____

Insured's ID # _____

Insured's Employer _____

Secondary

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # (____)_____

Group or Plan # _____

Insured's Name _____

Relationship to Patient _____

Insured's Birthdate ___/___/_____ SS# _____

Insured's ID # _____

Insured's Employer _____

In the event of an emergency, is there someone who lives near you that we should contact?

Name _____

Relationship _____

Home # (____)_____ Wk# (____)_____

MEDICAL HISTORY

Do you have a personal Physician? ☐Yes ☐No

Physician's Name _____

Phone # (____)_____

Date of last visit _____

Are you currently under the care of a physician? ☐Yes ☐No

Please explain _____

_____

_____

I understand that the information I have given today is correct to the best of my knowledge and that it is my responsibility to inform this office of any change in my medical status.
I have been informed of the dental materials fact sheet and authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment.
I understand that I am responsible for payment of services rendered.
Our office is HIPAA compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

Signature **Date**

Continue to Medical History Form