Rodrigo J. Cabrera DDS & DENTAL ASSOCIATES

# Patient Information Form:

Name: _____Sex: ____ M ____F

Home Phone:_____ Work Phone: _____Cell Phone: _____

Email Address:_____

Home Address: _____ Apt#_____City: _____Zip Code:_____

Drivers License/ID Number: _____ State: _____ Exp. Date: _____

## Employer Information

Employer Name and Address: _____

Employer Phone: _____

Spouse's Name: _____Work Phone: _____

Social Security #: _____Date of Birth: _____

Nearest relative not living with you:_____ Phone:_____

Primary Care or Referring Physician:_____ Phone: _____

Previous Dentist: _____Phone:_____

Whom may we contact in the case of an emergency? _____Phone:_____

Whom may we thank for referring you to us? _____ Phone:_____

Who is responsible for this bill?_____

## Insurance Information

Name of Subscriber: _____ Relationship to Patient: _____

Birthdate: _____ Social Security Number: _____

Name of employer: _____ Office Phone: _____

Insurance Company: _____ Group #:_____ Employer/ID#: _____

Insurance company address: _____ City/State: _____ Zip: _____

Do you have Secondary Insurance? ___Yes ___No

Name of Subscriber: _____Relationship to Patient: _____

Birthdate: _____ Social Security Number: _____

Name of employer: _____ Office Phone: _____

Insurance Company: _____ Group #: _____ Employer/ID# _____

Insurance company address: _____ City/State: _____ Zip: _____

If this claim is accident related, please provide details of the accident:

_____

Did you sustain an injury at work?

□Yes ■No

Are your injuries accident related?

□Yes ■No

Are you currently employed?

□Yes □No

Have you ever served in the military?

□Yes □No

Are you covered under an employer or union policy?

□Yes □No

Is your spouse or other family member employed?

□Yes □No

Do you have a secondary or medical insurance policy?

□Yes □No

Are you covered under any other healthcare plan?

□Yes □No

**Medical History:** Do you have or had any of the following (Please check all that apply)

| | | |
|---|---|---|
| ☐ Anemia | ☐ Diabetes | ☐ Lesions |
| ☐ Arthritis/ Rheumatism | ☐ Epilepsy | ☐ Mitral Valve Prolapse |
| ☐ Artificial Heart Valves | ☐ Fainting | ☐ Pacemaker |
| ☐ Artificial Joints | ☐ Glaucoma | ☐ Psychiatric Care/Problems |
| ☐ Asthma | ☐ Headaches | ☐ Radiation Treatment |
| ☐ Back Problems | ☐ Heart Murmur | ☐ Respiratory Disease |
| ☐ Bleeding Abnormalities | ☐ Heart Attack | ☐ Rheumatic Fever |
| ☐ Blood Disease | ☐ Heart Problems | ☐ Skin Rash |
| ☐ Cancer | ☐ Hemophilia | ☐ Sinus Problems |
| ☐ Chemical Dependency | ☐ Hepatitis | ☐ Stroke |
| ☐ Chemotherapy | ☐ High Blood Pressure | ☐ Thyroid Problems |
| ☐ Circulatory Problems | ☐ HIV Positive | ☐ Tobacco Habit |
| ☐ Congenital Heart Disease | ☐ Kidney Disease | ☐ Tuberculosis |

Are there any other health conditions you have that are not listed?
If so, please explain: _____
Please List all Allergies: _____
Please List all Medications you are currently taking:_____
_____

Women Only:
Are you Pregnant? ◯ Yes ◯ No Weeks:____ Nursing? ◯ Yes ◯ No
Had an exposure to HPV? ◯ Yes ◯ No

Date of Last Dental Exam: _____ Reason for Today's Visit: _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or in the above information. **This information will be kept confidential.**

Signature _____ Date_____