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| --- |
| **MEDICAL ALERTS:** |

**CURRENT PATIENT INFORMATION FORM**

**CHILD – NEW PATIENT**

FULL NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (First) (M.I.) (Last)

SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (# & Street Name) (Apt #) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(City) (State) (Zip Code)

HOME #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENT’S INFORMATION**

MOTHER’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (First) (M.I.) (Last)

ADDRESS: (If different) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# & Street Name Apt # City Zip Code

HOME #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BUSINESS #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MOTHER’S SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

FATHER’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (First) (M.I.) (Last)

ADDRESS: (If different) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 # & Street Name Apt # City Zip Code

HOME #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BUSINESS #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FATHERS’S SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY INSURANCE COVERAGE**

**SUBSCRIBER’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RELATION TO PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMPLOYER’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME OF INSURANCE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I.D. #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SECONDARY INSURANCE COVERAGE**

**SUBSCRIBER’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RELATION TO PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMPLOYER’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME OF INSURANCE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I.D. #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL QUESTIONS**

**ALLERGIES**

**(Circle Yes or No)**

**Y N Aspirin Y N Codeine Height: \_\_\_\_\_\_\_\_\_\_\_**

**Y N Dental Anesthetics Y N Erythromycin Weight: \_\_\_\_\_\_\_\_\_\_\_**

**Y N Jewelry Y N Latex**

**Y N Metals Y N Penicillin**

**Y N Tetracycline Y N Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Conditions: Do you have or have you ever had……(circle Y or N)**

**Y N Abnormal Bleeding Y N Difficulty Breathing Y N HIV + AIDS Y N Thyroid Problems**

**Y N Alcohol Abuse Y N Drug Abuse Y N Kidney Problems Y N Tuberculosis**

**Y N Allergies Y N Emphysema Y N Liver Disease Y N Ulcers**

**Y N Anemia Y N Epilepsy Y N Low Blood Pressure Y N Veneral Disease**

**Y N Angina Pectoris Y N Fainting Spells Y N Mitral Valve Prolapse Y N Yellow Jaundice**

**Y N Arthritis Y N Fever Blisters Y N Pace Maker**

**Y N Artificial Bones Y N Frequent Headaches Y N Pneumocystitis**

**Y N Artificial Heart Valve Y N Glaucoma Y N Psychiatric Problems**

**Y N Asthma Y N Hay Fever Y N Radiation Therapy**

**Y N Blood Transfusion Y N Heart Attack Y N Rheumatic Fever**

**Y N Cancer-Chemotherapy Y N Heart Surgery Y N Seizures**

**Y N Colitis Y N Hemophilia Y N Shingles**

**Y N Congenital Heart Defect Y N Hepatitis A Y N Sickle Cell Disease**

**Y N Cosmetic Surgery Y N Hepatitis B Y N Sinus Problems**

**Y N Diabetes Y N High Blood Pressure Y N Stroke**

**Is there any disease, condition, or problems that you think this office should know about that is not covered above? If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FEMALES ONLY**

**(Please answer the following)**

**Y N Are you taking birth control pills**

**Y N Are you pregnant? If yes, # of weeks: \_\_\_\_\_\_\_\_\_\_**

**Y N Are you nursing?**

**RESPONSIBLE PARTY FOR PATIENT**

**It is understood that I/We have the principal financial obligation for treatment of the above named patient. Every reasonable effort will be made by Fred Knaysi, D.D.S., P.C. to secure all fees and costs through the insurance carrier named above. If however, said insurer fails to meet this obligation in whole or part, I/We agree to be responsible for the fees and costs involved in the treatment of the above named patient by Fred A. Knaysi, D.D.S., P.C. I/We further covenant and agree that should I/We fail to meet the aforementioned financial obligation, I/We will pay all additional costs of collection, including but not limited to, court costs, attorney’s fees of thirty-three percent and legal interest on the balance due from the date of this agreement.**

**NAME & ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(If Patient is under 18, Must be signed by Parent or Legal Guardian)**