Whom may we thank for referring you?

☐ One of our valued patients (name of patient) ______________________

☐ Website ☐ Advertisement

☐ Other ______________________

Patient Information Form

Today's Date ______________

Patient Name: First ______________ MI ______ Last ______________ Nickname ______________

Address: Street ______________ City ______________ State ______ Zip ______________

Phone: Home ______________ Work ______________ Mobile ______________ **Email:** ______________

Social Security Number ______________ Driver License # ______________ **Date of Birth** ______________

Patient Employed by ______________ Occupation ______________ Phone ______________

Address: Street ______________ City ______________ State ______ Zip ______________

Sex ☐ Male ☐ Female Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

In case of emergency, who should be notified? ______________________

Relationship to Patient ______________ Home Phone ______________ Mobile Phone ______________

Is the patient a Minor? ☐ Yes ☐ No Full-time Student ☐ Yes ☐ No Name of School ______________

Name of Responsible Party: First ______________ Last ______________

Date of Birth ______________ Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other ______________

If patient is a Minor, primary residency ☐ Both Parents ☐ Mom ☐ Dad ☐ Step Parent ☐ Shared Custody ☐ Guardian

Address: Street ______________ City ______________ State ______ Zip ______________
(if different from patient)

Phone: Home ______________ Work ______________ Mobile ______________

Employer ______________ Occupation ______________ Phone ______________
(if different from above)

Address: Street ______________ City ______________ State ______ Zip ______________

Circle YES if it applies

1. Are you having pain or discomfort at this time? .... YES
2. Do you feel very nervous about having dental treatment? .... YES
3. Have you ever had a bad experience in the dental office? .... YES
4. Have you been a patient in the hospital during the past two years? .... YES
5. Have you been under the care of a medical doctor during the past two years? .... YES
6. Have you taken any medicine or drugs during the past two years? .... YES
7. Do you smoke or use tobacco products? .... YES
8. Do you need to pre-medicate for dental treatment? .... YES

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the dentist or a clinical staff member at the next appointment without fail.

Permission is hereby granted to the dentists of the Olive Dental Group to administer local anesthesia or sedation (with my consent) and render any dental services as deemed necessary for me.

NOTE: Your first visit is on a cash basis. Patients remain on a cash basis UNTIL THE NECESSARY INSURANCE FORMS ARE SUPPLIED and/or financial arrangements are made. Please allow four to six weeks for the insurance predetermination or payment. I personally accept legal responsibility for payment of all dental services regardless of dental insurance coverage.

Signed ______________________________________

Patient or person authorized to consent for patient.