



DAVID L. MAISEY

DENTISTRY

PATIENT DATA SHEET

Patient's Last Name: _____ First Name: _____ MI: _____ Date: _____
Mailing Address: _____ Apt. No.: _____
City: _____ State: _____ Zip Code: _____ Sex: Male / Female
Home Phone: (____) _____ Work Phone: (____) _____
Date of Birth: _____ Social Security Number: _____ - _____ - _____
Residence Address (if different): _____
Employer's Address: _____

If Patient is a Minor: (parents are responsible for fees)

1. Mother's Last Name: _____ First Name: _____ MI: _____
Social Security Number: _____ - _____ - _____
2. Father's Last Name: _____ First Name: _____ MI: _____
Social Security Number: _____ - _____ - _____

Insurance Information:

1. Primary Insurance Co.: _____ Policy/Group No.: _____ Policy Owner: _____
Insurance Co. Address: _____ City: _____ State: _____ Zip: _____
Employer: _____
Policy Owner's Date of Birth: _____ Social Security Number: _____ - _____ - _____
2. Secondary Insurance Co.: _____ Policy/Group No.: _____ Policy Owner: _____
Insurance Co. Address: _____ City: _____ State: _____ Zip: _____
Employer: _____
Policy Owner's Date of Birth: _____ Social Security Number: _____ - _____ - _____

3. Medicaid Coupon Number: _____

Are any family members seen in this office? (yes / no) Name: _____

As a courtesy to our patients, we will submit your insurance for you. It is important that you realize that we are not your insurance company. If you have difficulty or frustration with the speed of payment or the amount of payment by your carrier, please direct that frustration to the insurance carrier.

Signature Files:

1. I realize that I am personally responsible for the payment on all services rendered on my behalf or on the behalf of my dependent family members. (Signature) _____
2. I authorize the release of any information relating to insurance claims. (Signature) _____
3. I hereby authorize payment directly to the treating dentist, Dr. Maisey, for group benefits otherwise payable to me. (Signature) _____

Health History & Related Information:

In order to provide the best health care possible, we need an accurate history. Please CIRCLE any of the following that you/ patient have been diagnosed or treated for.

- hepatitis heart murmur metal allergies allergies
HIV positive prosthetic replacements mitral valve prolapse anemia
AIDS taking birth control pills diabetes liver disease
transfusions bacterial endocarditis arthritis bleeding problems
IV drug use (ever) congenital cardiac malformations kidney disease surgery
tuberculosis rheumatic fever high blood pressure use tobacco
cold sores (herpes) heart disease malignancies (tumors) drug allergies
oral venereal disease hypertrophic cardiomyopathy asthma Pregnant Now: Yes / No

Are you under a physician's care at the present time: (Yes / No) For what? _____

I am presently taking the following medications: _____

Referred by: _____

Health History Update & Patient Initials:

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____