Eastchester	Dental	Care,
PLIC		

Patient Information

Patient Name:	First	T	oday's Date:
Last,			
Gender: Male□ Female□	Marital Status: Single ☐ Marrie	d ☐ Child ☐ Student: Yes☐ N	No□
Social Security #:		Date of Birth:	
(Home phone):	(Cell):	
(Work):	Ext:	Email:	
Address:			Apartment #
			·
City	Employme	State Int Information	Zip Code
The	following is for: The patient		ayment 🗆
Employer Name:		Occupation:	
Address:			
		Information	
Date of Last Dental Visit:	Reaso	on for this visit:	
Have you ever had any AIDS Allergies Allergies Arthritis Artificial Joints Asthma Blood Disease Cancer Diabetes Dizziness Epilepsy Have you ever had any If yes, please explain: Have you been admitted If yes, please explain: Are you now under the	of the following? Please ch Excessive Bleeding Fainting Glaucoma Growths Hay Fever Head Injuries Heart Disease Heart Murmur Hepatitis High Blood Pressure Jaundice Kidney Disease complications following denta	eck those that apply: Liver Disease Mental Disorders Nervous Disorders Pacemaker Are you currently Pregnant Yes No Radiation Treatment Respiratory Problems Rheumatic Fever Rheumatism Sinus Problems I treatment? Yes No	□ Stomach Problems □ Stroke □ Tuberculosis □ Tumors □ Ulcers □ Venereal Disease □ Codeine Allergy □ Penicillin Allergy OTHER: □ □
Are you taking any med			
have any change in my h Whom may we thank for	ealth, I will inform the doctors Referral	at the next appointment with Information Another patient, friend	ed are true and correct. If I ever hout fail. Please Initial:

Name:			
Last	First		☐ Male ☐ Female
Social Security #:		Birth Date:	
			Best time to call:
Email Adrress:			
Address:			
	Insuranc	e Information	
Primary Name of Insured:			is insured a patient? ☐ Yes ☐ No
nsured's Birth Date:/	/ Ins ID/SS #:	//	
nourod'o Addrood			
insured's Address:	Street	City	State Zip Code
Patient's relationship to	insured: □ Self □ Spous	se 🗆 Child 🗆 Other	r
·	•		
nsured's Employer Name:			
Secondary			
Name of Insured:	First	MI	Ins insured a patient? ☐ Yes ☐ N
nsured's Birth Date:	_// Ins ID/SS #: _	//	Group #:
nsured's Address:	Street	City	01-1- 7"- 0-1-
		City	State Zip Code
Patient's relationship to nsurance Plan Name & Ph	o insured: ☐ Self ☐ Spous	se □ Child □ Other	State Zip Code
Patient's relationship to Insurance Plan Name & Ph Signature of person respon	o insured: □ Self □ Spous none#:	se □ Child □ Other	State Zip Code
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