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Patient Information

Date _____

Patient Name: _____ _____ _____ _____ Date of Birth _____
Last First MI (Preferred Name)

☐ Male ☐ Female ☐ Single ☐ Married ☐ Child ☐ Other Social Security#: _____ *DL#:* _____

Phone (Home): _____ (Work): _____ (Ext): _____ (Mobile): _____

Email Address: _____ Which way do you prefer that we contact you? _____

Address: _____ _____
Street Apartment #

_____ _____ _____
City State Zip Code

Employer Name _____ Occupation _____

Health Information

Have you ever had or have any of the following? Please check those that apply:

☐ AIDS
☐ Allergies _____ _____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer, type? _____
☐ Diabetes, type? _____
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding, please explain what caused it _____
☐ Fainting
☐ Glaucoma
☐ Gum Disease
☐ Headaches Migraine? _____
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis, type? _____
☐ High Blood Pressure
☐ Lung Disease
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Oral Cancer or lesion
☐ Pacemaker
☐ Pregnancy (presently) Due date: _____
☐ Radiation Treatment, When? _____
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Thyroid problems
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy

Please list any other drug allergies not mentioned here
_____
_____
_____

Please list any PRESCRIPTION and/or OTC (Over The Counter) drugs you are currently taking, including vitamins or herbs.
_____
_____
_____

Is there anything not listed here concerning your medical history we need to know about? ☐ Yes ☐ No
If yes, please explain:
_____
_____
_____

• Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____

• Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____

• Name of Physician: _____ Phone: _____

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Who can we thank for referring you to our office? _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #- _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Do we have your permission to contact you at your work number? ☐ Yes ☐ No

Address: _____ _____
Street City State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First M1

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:, _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Describe in detail your main concern for your visit with Dr Doshi.?

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party