Welcome To Our Office
Dr. Chad Huguenin LLC

Patient Information

Patient Name: ____ Date: __________

Last, First MI (Preferred Name)

E-Mail____________________________________ Sex: M F Marital Status: M S D W

Social Security #: ______________________ Birth Date: ________________________

Phone (Home): ___________(Work): _____________ Ext: _____Cell/Other: ____________

Address____

____

City State Zip Code

Emergency Contact____________________Phone:_________________Relationship________

Health Information

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

- ☐ AIDS/HIV
- ☐ Allergies __________
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stent
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

- ☐ ____________
- ☐ Are you taking Aspirin, Baby Aspirin or any other type of blood thinner? ___________

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ____
- Have you been admitted to a hospital or needed emergency care during the past two years?(any surgeries)☐ 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: ____________
- Are you currently taking any prescribed medications or herbal supplements? ☐ Yes ☐ No
  If yes, please explain: ____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____
- What was the reason for your last trip to the dentist? _______________________________________
  Date: _______________________
- Why did you leave your previous dental office? ____
- What is the most important thing we can do for you today? ____________________________________
- Do you use alcohol, tobacco or any other drugs? Yes No If yes, please identify____________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

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 ____________________

Name of person or office referring you to our practice____

Insurance Information

Primary

Name of Subscriber: ____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Subscriber's Birth Date: _________________ ID #: ______________________ Group #: ___________________

Subscriber's Address: ____

Street City State Zip Code

Subscriber's Employer Name: ____

Address: ____

Street City State Zip Code

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

Insurance Plan Name and Phone : ____

____

Secondary

Name of Subscriber: ____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Subscriber's Birth Date: _________________ ID #: ______________________ Group #: ___________________

Subscriber's Address: ____

Street City State Zip Code

Subscriber's Employer Name: ____

Address: ____

Street City State Zip Code

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

Insurance Plan Name and Phone: ____

____

Signature of patient, parent or guardian ____ Date ________________________

Signature of patient, parent or guardian ____ Date ________________________

Signature of patient, parent or guardian ____ Date ________________________

Signature of patient, parent or guardian ____ Date ________________________