



Jenny G. Kopp D.D.S. M.S.
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Confidential Personal and Medical History

Patient's Name: _____ Today's Date _____
 Address: _____ City: _____ ZIP: _____
 Phone (Home) _____ (Cell) _____ (Work) _____
 Social Security #: _____ Date of Birth: _____
 Name you prefer to be called: _____ Hobbies: _____
 Spouse's Name: _____ Date of Birth: _____
 Spouse's Social Security #: _____
 General Dentist: _____
 If Minor, Guardian's Name: _____
 Emergency contact: _____ Phone: _____

Dental Insurance Information

Subscriber's Name: _____ Date of Birth: _____
 Name of Insurance Company: _____
 Claim's Address: _____
 Telephone: _____ Group/Policy/Plan #: _____
 Employer's Name: _____
 Address: _____ Telephone: _____

Medical History

Do You Have or Have You Ever Had Any of the Following?

Y	N		Y	N		Y	N	
-	-	High Blood Pressure	-	-	Diabetes	-	-	Asthma
-	-	Low Blood Pressure	-	-	Kidney Disease	-	-	Tuberculosis
-	-	Heart Attack	-	-	Dialysis Shunt	-	-	Arthritis
-	-	Artificial Heart Valve	-	-	Stroke	-	-	Joint Replacment/Implant
-	-	Rheumatic Fever	-	-	Hepatitis/Jaundice	-	-	Stomach Ulcers
-	-	Heart Murmur	-	-	Liver Disease	-	-	Bleeding Disorders
-	-	Mitral Valve Prolapse	-	-	Blood Thinners	-	-	Tumors or Cancer
-	-	Pacemaker	-	-	Sexually Transmitted Disease	-	-	Drug/Alcohol Addiction
-	-	Heart Surgery	-	-	AIDS or HIV Postive	-	-	Currently Pregnant

List any Medications/Drugs You Are Taking: _____

List Any Allergies You May Have: _____

I ACCEPT FULL RESPONSIBILITY FOR ALL TREATMENT PERFORMED BY PREMIER ENDODONTIC ASSOCIATES. I understand payment is expected at the time of service. I understand that insurance coverage is a contractual arrangement between my insurance company and myself. I understand that should my account become past due over 60 days, I will be responsible for all fees, interest charges, late charges and all costs of collection including, but not limited to, attorney's fees and court costs. My signature on this form authorizes the release of any information relating to claims filed on my behalf and also authorizes payment sent directly to Premier Endodontic Associates.

Date: _____

Signature of Patient, or Legal Guardian