ANESTHESIA PATIENT INFORMATION (CONFIDENTIAL)

Today's date: _____
Patient Name (Last, First): _____ DOB: _____

Age: _____ Height: _____ Weight: _____Gender: Male / Female

Responsible Party's Name:_____
Address: _____ City: _____ State: _____Zip: _____
Home: (_____)_____ Cell: (_____)_____ Work: (_____)_____
Email(s): _____
What is the best way to contact you prior to your appointment? _____
Emergency Contact Name: _____ Phone: _____

Insurance Information

Insured's Name (Last, First): _____ DOB: _____
Dental Insurance Carrier: _____ Subscriber_____
ID:_____ Health Insurance Carrier: _____
Subscriber ID:_____
Health insurance claim form (HICF 1500) Requested: Y ◯ N ◯

As part of the Affordable Care Act, our office is required to record 'meaningful use data' for each patient. Please answer the following:
Race: [ ]American Indian or Alaska Native. [ ]Asian [ ] Black or African American
[ ] Native Hawaiian or other Pacific Islander [ ]White [ ]Prefer Not to Answer
Ethnicity: [ ]Hispanic or Latino [ ] Not Hispanic or Latino o Prefer Not to Answer
Preferred Language: [ ]English [ ]Spanish [ ]Other _____

Treatment Information

Estimated Length of Appointment: _____Estimated Fee:_____
Appointment Date: _____ Rendering Dentist:_____

Medical Information

Current Medications

Medication	Dose Given:	Frequency (ie 3x per day)

Known medical conditions:
Known drug allergies: