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: ____