Adam J. Frieder, DDS, LLC

401 W. Seventh St., Frederick, Md. 21701 (301) 662-7766

We'd like to get to know you better! Date_____

PERSONAL INFORMATION

Patient Name_____ Nickname_____ Sex_____

Birth date_____ Social Security #_____-____-_____ Occupation_____

Person Responsible for Account _____ Relationship _____

Social Security #_____-____-_____ Birth date_____ Driver's License #_____

Patient Address_____

Billing Address_____

Home Phone _____ Business Phone _____

Mobile Phone _____ E-Mail Address _____

Responsible Party's Phone_____ Referred by _____

From the phone numbers above, please circle the best one for us to reach you during the daytime.

EMPLOYER AND INSURANCE INFORMATION

Please provide office with a copy of your insurance card.

Name of primary insurance holder_____ Relationship_____

Insurance Company _____ Group #_____

Ins. Co. Phone _____ Ins. Co. Address_____

MEDICAL HEALTH

Name and address of physician_____
Phone # of physician _____
Have you been under a physician's care during the past 2 years? _____
For_____
Have you been treated in the hospital in the last two years? _____
For _____
Have you ever had major surgery? _____
If female, are you on hormones or birth control? ___ Are you pregnant or nursing? _____
Have you ever had a blood test for hepatitis? ____ Were you vaccinated? _____
Have you ever had canker or cold sores on your lips, tongue, gums or body? _____
Are you now taking, or have you taken any prescription drugs during the past year? _____
Please list: _____
_____
Are you allergic to? _____Penicillin _____Codeine _____Local Anesthetics ____Latex
Allergies to Other Medications _____
Have you been out of the country within the last two years? _____