RON MAMRICK
1807 Huguenot Road, Ste. 124
Midlothian, VA 23112
Tel: 804-423-1600
Fax: 804-423-1602
Info@MamrickDentistry.com

PATIENT INFORMATION AND HEALTH HISTORY

Patient Name _____ (Last) _____ (First) _____ (MI)

Preferred name: _____ Title: _____ (Mr/Ms/Mrs/etc) Gender: M F

Family Status: Married Single Child Other Birthdate: _____ MM/DD/YYYY

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Email Address: _____ Referred by: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Responsible Party Information (if other than Patient):

Name _____ (Last) _____ (First) _____ (MI)

Preferred name: _____ Title: _____ (Mr/Ms/Mrs/etc) Gender: M F

Family Status: Married Single Child Other Birthdate: _____ MM/DD/YYYY

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Dental Insurance Information *(if applicable)*

Primary Dental Insurance		Secondary Dental Insurance	
Insurance Carrier:		Insurance Carrier:	
Name of Insured:		Name of Insured:	
Insured's Date of Birth:		Insured's Date of Birth:	
Insured's SSN or ID#:		Insured's SSN or ID#:	
Group #:		Group #:	
Insured Employer's Name:		Insured Employer's Name:	

Health History Information

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions about your health. This information is to allow us to provide appropriate care for you This office does not use this information to discriminate.

Do you have any of the following diseases or problems?

Active Tuberculosis	☐ Yes ☐ No	Cough that produces blood	☐ Yes ☐ No
Persistent cough greater than a 3 week duration	☐ Yes ☐ No	Been exposed to anyone with tuberculosis	☐ Yes ☐ No

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

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Name of Insured:		Name of Insured:	
Insured's Date of Birth:		Insured's Date of Birth:	
Insured's SSN or ID#:		Insured's SSN or ID#:	
Group #:		Group #:	
Insured Employer's Name:		Insured Employer's Name:	

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