

Date: ____/___/___

5/11

Patient Information: (Confidential)			Patient#
Patient Name:	_	Birthdate://	SS#/SIN:
Address:	_	City:	State: Zip:
Email:	_	Home Phone:	Cell Phone:
Circle One in Each Category: Male or Female	Adult or Minor	Single Married Widowed	Separated or Divorced
Employer :		Employer Phone:	
Employer Address:	_	City:	State: Zip:
Person to contact in case of emergency:		Emergency Phone:	
Is it okay to discuss treatment & cost with respons	sible party and/or ins	sured? \(\sqrt{YES} \sqrt{NO} \)	
esponsible Party:			
Name of Person Responsible for this Account:		Relationship t	o Patient:
Address:	_	City:	State: Zip:
Birthdate:/		SS #:	Home Phone:
Employer:	_	Work Phone:	Cell Phone:
Is Responsible Party a Patient in our practice? Yes or N	_ 'o		
rimary Dental Insurance Information:			
Name of Person Carrying the Insurance:		Relationship to Patient:	
Single Married Widowed Separated or Di			
Birthdate:/		·	Home/Cell Phone:
Home Address:			State: Zip:
Name of Employer:			Work Phone:
Insurance Company:		Group #:	
Insurance Co. Address:		City:	
		_	
DO YOU HAVE <u>ADDITIONAL</u> DENTAL INSURANCE?		YES NO	IF YES, COMPLETE THE FOLLOWING:
Name of Person Carrying the Insurance:		Relationship to Patient:	
Single Married Widowed Separated or Di	ivorced		
Birthdate:/	SS#/SIN:		Date Employed://
Name of Employer:		Union or Local #:	Work Phone:
Address of Employer:		City:	State: Zip:
Insurance Company:		Group #:	
Insurance Co. Employer:		City:	State: Zip:
How much is your deductible?:		ow much have you used?:	Max. annual benefit:
Name of Person Carrying the Insurance:		Relationship	to Patient:
Birthdate:/	SS#/SIN:		Date Employed:/
Name of Employer:		Union or Local #:	Work Phone:
Address of Employer:		City:	State: Zip:
Insurance Company:		Group #:	
Insurance Co. Employer:		City:	State: Zip:
How much is your deductible?:		ow much have you used?:	Max. annual benefit:

(Over Please)

Patient Medical History:

No wheen hospitalized for any surgical operations or serious any of the following? Yes No Millesses within the last five (5) years? fyes, please explain: Are you taking any medication(s) including non-prescription medicine? Geodure Geod	Are you currently under medical treatment?	Physician:	Office Phone:		·						_
Are you currently under medical treatment?	Are you currently under medical treatment?			Vas	No						
Howe you been hospitalized for any surgical operations or serious	Have you been hospitalized for any surgical operations or serious	Are you currently under medical tre	atment?		ñ	11.	Are y	ou alle	ergic to or have you had any reaction to		
If yes, plots are plain: Are you taking any medication(s) including non-prescription medicine? Solid Drugs Barbiturates Sulfa Drugs Barbiturates Solid Drugs Barbiturates Latex Rubber Any metals (e.g. nickel, mercury, etc.) Latex Rubber Any metals (e.g. nickel, mercury, etc.) Latex Rubber Other (splose list.) Latex Rubber Any metals (e.g. nickel, mercury, etc.) Latex Rubber Other (splose list.) Latex Rubber Any metals (e.g. nickel, mercury, etc.) Latex Rubber Other (splose list.) Latex Rubber Any metals (e.g. nickel, mercury, etc.) Latex Rubber Other (splose list.) Latex Rubber Any metals (e.g. nickel, mercury, etc.) Latex Rubber Other (splose list.) Latex Rubber Any metals (e.g. nickel, mercury, etc.) Latex Rubber With Annown Illeas (Isalian more than 3 weeks 12	flyes, plotse explains:	Have you been hospitalized for any	surgical operations or serious				any o	f the f	ollowing?	Yes	No
Are you taking any medication(s) including non-prescription medicine? flyes, what medication? flyes, what medication(s) flow you ever taken Fen-Phen/Redux? Aspirin	Are you taking any medication(s) including non-prescription medicine? flyes, what medication? Barbitrustes Barbitrustes	illnesses within the last five (5) year	s?	П			Local	Anest	hesia (e.g. Novocain)		
Are you taking any medication(s) including non-prescription medicine?	Are you taking any medication(s) including non-prescription medicine? Seditives Sedit	If yes, please explain:					Penic	illin or	any other Antibiotics		
	If yes, what medication?: Sedatives Goldine Goldin						Sulfa	Drugs			
Howe you ever taken Fen-Phen/Redus? Aspirin Aspiri	Indine India Ind	Are you taking any medication(s) in	cluding non-prescription medicine?				Barbi	turate	5		
Have you ever taken Fen-Phen/Redus? Aspirin Aspirin Aspirin Aspirin Aspirin Aspirin Aspirin Any metals (e.g. nickel, mercury, etc.) Interest Nobber Content of the phiposphonhores? Content of the phiposphonhores Cont	Have you ever taken Fen-Phen/Redux?	If yes, what medication?:									Щ
Have you ever taken Fosamax, Boniva, Actonel or any cencer medications Any metals (e.g. nickel, mercury, etc.)	Have you ever taken Fosamax, Bonivo, Actonel or any cancer medications Any metals (e.g. nickel, mercury, etc.)	Have you over taken Fon Bhon/Bad		_							님
Latex Rubber Chiefs (please list) Chief	biphosphonates?			ш	Ш		- 1			H	
Hove you taken Vapara, Revalio, Calls or Levitra in the last 24 hours? —	Hove you taken Viagra, Revotio, Cialis or Levitra in the last 24 hours? 12. Do you have a presistent cough or throat clearing associated with a known illness (lasting more than 3 weeks)?			\Box			-			\mathbf{H}	믬
last 24 hours?	last 24 hours?			Ш	Ш						닐
Do you use tobacco?	Do you use tobacco?					12		••			∟ړ
Do you use controlled substances?	Do you use controlled substances?			H	H	12.	-				<i>"</i>
Are you wearing contact lenses?	Are you wearing contact lenses?	•		H	H	12				· Ш	ш
Have you ever had previous dentures or partials?	Have you ever had previous dentures or partials? yes, date of placement	•		H	H	13.					
Are you taking oral contraceptives?	Are you taking oral contraceptives?			H	H		-			\vdash	H
Do you have or have had any of the following? Ves No Yes No	Do you have or have had any of the following? Yes		es or purtiuis:	Ш	Ш		•		•	H	뭐
Yes No	Heart Disease Cardiac Pacemaker Cardiac	ij yes, aate of placement					are y	υ τακ	ing oral contraceptives?	Ш	Ш
Heart Attack Heart Attack Cardiac Pacemaker Heart Attack Heart Attack Heart Attack Heart Murmur Stroke Heart Murmur Heart	Heart Attack Gardiac Pacemaker Gasily Winded Gasily Win	l. Do you have or have had any of th	e following?								
Heart Attack Cardiac Pacemaker Easily Winded Heart Murmur Stroke Stroke Heart Murmur Heart Mur	Heart Attack		Yes No				Yes	No		Yes	No
Heart Attack Cardiac Pacemaker Easily Winded Heart Murmur Stroke Stroke Heart Murmur Heart Mur	Heart Attack	High Blood Pressure	Heart Disease						Chest Pains		
Rheumatic Fever	Rheumatic Fever	<u> </u>	Cardiac Pacemaker	r			П	同		Ħ	同
Swollen Ankles	Swollen Ankles		= =					Ħ	•		Ħ
Frequently Tired	Frequently Tired		= -				П	Ħ		Ħ	Ħ
Anemia Glaucoma Gl	Anemia			-			Ħ	Ħ		Ħ	H
Low Blood Pressure	Low Blood Pressure	_					H	H		=	H
Epilepsy / Convulsions	Epilepsy / Convulsions							Н		\blacksquare	\vdash
Leukemia	Liver Disease										
Joint Replacement or Implant Heart Trouble Heart Tro	Joint Replacement or Implant Heart Trouble	Epilepsy / Convulsions	Cancer				Ш	Ш	Radiation Therapy	Ш	Ш
Hepatitis / Jaundice Respiratory Problems AlDS or HIV Infection Sexually Transmitted Disease Mitral Valve Prolapse Thyroid Problem Stomach Troubles / Ulcers Other Other Other Are there Dental Conditions / Issues we need to be Aware of ? Are there Dental Conditions / Issues we need to be Aware of ? Italy that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answer I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payers and/or have practitioners. I authorize and request my insurance company to pay directly to the Family Dental Center benefits otherwise payable to me. understand that my dental insurance carrier may pay less than the actual bill for services. I acknowledge that I have read and understand Family Dental Center's Insurance and Financial Policy, Payment for Services and Notice of Prin Practices. I agree to be responsible for payment of all services rendered on my behalf. ((Signature of Patient or Guardian) (Date) edical History Reviewed: Date Changes Initials	Hepatitis / Jaundice	Leukemia	Arthritis				Ш	Ш	Liver Disease	Ш	Ш
AlDS or HIV Infection	AlDS or HIV Infection	Diabetes	Joint Replacement	or Im	plant .				Heart Trouble		
Thyroid Problem	Thyroid Problem Stomach Troubles / Ulcers Other Other Are there Dental Conditions / Issues we need to be Aware of ? uthorization and Release: I certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answ I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payers and/or practitioners. I authorize and request my insurance company to pay directly to the Family Dental Center benefits otherwise payable to me understand that my dental insurance carrier may pay less than the actual bill for services. I acknowledge that I have read and understand Family Dental Center's Insurance and Financial Policy, Payment for Services and Notice of Paractices. I agree to be responsible for payment of all services rendered on my behalf. (Signature of Patient or Guardian) (Date) I changes Initials Changes Initials Changes Initials Changes Initials Changes Initials Changes Initials Changes Initials Changes Initials Changes Initials Changes Initials Changes Initials Changes Initials Changes Initials Changes Initials Changes Initials Changes Initials Changes Initials Changes Initials Changes Initials Changes Initials Changes Initials Changes Initials Changes Initials Changes Initials Changes Initials Changes Initials Changes Initials Changes Initials Changes Initials Changes Initials Changes Initials Changes Changes Changes Initials Changes Chan	Kidney Diseases	Hepatitis / Jaundice	e					Respiratory Problems		
Are there Dental Conditions / Issues we need to be Aware of ?	Are there Dental Conditions / Issues we need to be Aware of? Certify that have read and understood the above information to the best of my knowledge. The above questions have been accurately answ understand that providing incorrect information can be dangerous to my health. authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payers and/or practitioners. I authorize and request my insurance company to pay directly to the Family Dental Center benefits otherwise payable to me understand that my dental insurance carrier may pay less than the actual bill for services. I acknowledge that have read and understand Family Dental Center's Insurance and Financial Policy Payment for Services and Notice of P.	AIDS or HIV Infection	Sexually Transmitte	ed Dis	ease				Mitral Valve Prolapse		Ħ
uthorization and Release: I certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answer I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payers and/or hy practitioners. I authorize and request my insurance company to pay directly to the Family Dental Center benefits otherwise payable to me. understand that my dental insurance carrier may pay less than the actual bill for services. I acknowledge that I have read and understand Family Dental Center's Insurance and Financial Policy, Payment for Services and Notice of Printeractices. I agree to be responsible for payment of all services rendered on my behalf. (uthorization and Release: I certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answ I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payers and/or practitioners. I authorize and request my insurance company to pay directly to the Family Dental Center benefits otherwise payable to me understand that my dental insurance carrier may pay less than the actual bill for services. I acknowledge that I have read and understand Family Dental Center's Insurance and Financial Policy, Payment for Services and Notice of Paractices. I agree to be responsible for payment of all services rendered on my behalf. (Thyroid Problem	Stomach Troubles /	/ Ulce	rs			Ħ	Other		Ħ
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