Date: _____/_____/__________

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: _____-_____-______* *Alt. Phone: _____-_____-______*

Employer Address: ______________________________ *City: ____________________________* *State: ________* *Zip:___________*

Person to contact in case of emergency: ________________________________ *Emergency Phone: ______- ______ - ______*

Is it okay to discuss treatment & cost with responsible party and/or insured? ☐ *YES* ☐ *NO*

Responsible Party:

Name of Person Responsible for this Account: ____________________________ *Relationship to Patient: ______________________________*

Address: ________________________________ *City: ____________________________* *State: ________* *Zip: ____________*

Birthdate: _____/_____/__________ *SS #: ______-_____-______* *Home Phone: _____-_____-______*

Employer: ________________________________ *Work Phone: _____-_____-______* *Cell Phone: _____-_____-_____*

Is Responsible Party a Patient in our practice? Yes or No

Primary Dental Insurance Information:

Name of Person Carrying the Insurance: ____________________________ *Relationship to Patient: ______________________________*

Single Married Widowed Separated or Divorced

Birthdate: _____/_____/__________ *SS#/SIN: ________-______-_________* *Home/Cell Phone: _____-_____-______*

Home Address: ________________________________ *City: ____________________________* *State: ________* *Zip: ____________*

Name of Employer: ________________________________ *Date Employed: ___/___/___* *Work Phone: _____-_____-______*

Insurance Company: ________________________________ *Group #: _________________________* *Policy/ID #: ________________________*

Insurance Co. Address: ______________________________ *City: ____________________________* *State: ________* *Zip: ____________*

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? ☐ **YES** ☐ **NO** **IF YES, COMPLETE THE FOLLOWING:**

Name of Person Carrying the Insurance: ____________________________ *Relationship to Patient: ______________________________*

Single Married Widowed Separated or Divorced

Birthdate: _____/_____/__________ *SS#/SIN: ________-______-_________* *Date Employed: _____/_____/_________*

Name of Employer: ________________________________ *Union or Local #: _________________* *Work Phone: _____-_____-______*

Address of Employer: ______________________________ *City: ____________________________* *State: ________* *Zip: ____________*

Insurance Company: ________________________________ *Group #: _________________________* *Policy/ID #: ________________________*

Insurance Co. Employer: ____________________________ *City: ____________________________* *State: ________* *Zip: ____________*

How much is your deductible?: ____________________ *How 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 #: _________________________* *Policy/ID #: ________________________*

Insurance Co. Employer: ____________________________ *City: ____________________________* *State: ________* *Zip: ____________*

How much is your deductible?: ____________________ *How much have you used?: ____________* *Max. annual benefit: _______________*

(Over Please)

Patient Medical History:

Physician: ___________________________________ Office Phone: ________-________-__________ Date of Last Exam: _____/_____/_______

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you been hospitalized for any surgical operations or serious illnesses within the last five (5) years?	☐	☐
If yes, please explain: ____		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication?: ______________________________________		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications biphosphonates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐
9. Are you wearing contact lenses?	☐	☐
10. Have you ever had previous dentures or partials?	☐	☐
If yes, date of placement _________________________		

11. Are you allergic to or have you had any reaction to any of the following?

	Yes	No
Local Anesthesia (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Others (please list)__________________________	☐	☐
12. Do you have a persistent cough or throat clearing associated with a known illness (lasting more than 3 weeks)?	☐	☐
13: Women Only:		
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

14. Do you have or have had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	*Heart Disease*	☐	☐	*Chest Pains*	☐	☐
Heart Attack	☐	☐	*Cardiac Pacemaker*	☐	☐	*Easily Winded*	☐	☐
Rheumatic Fever	☐	☐	*Heart Murmur*	☐	☐	*Stroke*	☐	☐
Swollen Ankles	☐	☐	*Angina (Chest Pain)*	☐	☐	*Hay Fever / Allergies*	☐	☐
Fainting / Seizures	☐	☐	*Frequently Tired*	☐	☐	*Tuberculosis*	☐	☐
Asthma	☐	☐	*Anemia*	☐	☐	*Glaucoma*	☐	☐
Low Blood Pressure	☐	☐	*Emphysema*	☐	☐	*Recent Weight Loss*	☐	☐
Epilepsy / Convulsions	☐	☐	*Cancer*	☐	☐	*Radiation Therapy*	☐	☐
Leukemia	☐	☐	*Arthritis*	☐	☐	*Liver Disease*	☐	☐
Diabetes	☐	☐	*Joint Replacement or Implant*	☐	☐	*Heart Trouble*	☐	☐
Kidney Diseases	☐	☐	*Hepatitis / Jaundice*	☐	☐	*Respiratory Problems*	☐	☐
AIDS or HIV Infection	☐	☐	*Sexually Transmitted Disease*	☐	☐	*Mitral Valve Prolapse*	☐	☐
Thyroid Problem	☐	☐	*Stomach Troubles / Ulcers*	☐	☐	*Other _______________________*	☐	☐

Are there Dental Conditions / Issues we need to be Aware of ?____

____

Authorization 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 answered. 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 health practitioners. I authorize and request my insurance company to pay directly to the Family Dental Center benefits otherwise payable to me. I 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 Privacy Practices. I agree to be responsible for payment of all services rendered on my behalf.

X ____ ______/______/________

(Signature of Patient or Guardian) **(Date)**

Medical History Reviewed:

Date	Changes	Initials
_______/_______/_________	______________________________	____________
_______/_______/_________	______________________________	____________
_______/_______/_________	______________________________	____________