PATIENT INFORMATION

NAME_____
LAST FIRST MIDDLE

PLEASE CHECK ONE

_____MARRIED _____SINGLE _____ MINOR _____MALE _____ FEMALE

ADDRESS_____
STREET APT# CITY STATE ZIP

BIRTHDATE_____
MONTH DAY YEAR

TELEPHONE (_____)_____ (_____)_____ (_____)_____
HOME # CELL # WORK #

PLACE OF EMPLOYMENT_____

INSURANCE COMPANY_____ GROUP #_____

SS# OR ID # _____
(INFORMATION NECESSARY TO CONFIRM INSURANCE)

PERSON RESPONSIBLE FOR ACCOUNT

PLEASE CHECK ONE

_____PATIENT _____GUARDIAN _____ FATHER (OR HUSBAND) _____MOTHER (OR WIFE)

HAS ANY MEMBER OF YOUR FAMILY EVER BEEN TREATED IN OUR OFFICE? YES / NO

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

____*INTERNET* _____*YELLOW PAGES* _____ *ADVERTISEMENT* _____*INSURANCE*

_____ *EMPLOYEE* _____*FAMILY/FRIEND* _____ *OTHER*

EMERGENCY CONTACT (OUTSIDE OF IMMEDIATE FAMILY/HOUSEHOLD)

NAME_____

ADDRESS_____

CITY/STATE/ZIP _____

TELEPHONE# _____

MEDICAL HISTORY

DO YOU NOW HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

PLEASE CIRCLE
YES OR NO

Y ***N*** *HEART DISEASE (Heart valve replacement, mitral valve prolapse, bypass surgery, Pace-maker, heart murmur, stent, angioplasty, etc.)*

Y ***N*** *PROSTHETIC JOINT REPLACEMENT (Hip, Knee, _____)*

Y ***N*** *BLOOD PRESSURE: _____HIGH _____LOW*

Y ***N*** *BLEEDING PROBLEMS*

Y ***N*** *BLOOD DISEASE*

Y ***N*** *INFECTIOUS HEPATITIS*

Y ***N*** *AIDS EXPOSURE*

Y ***N*** *RHEUMATIC FEVER*

Y ***N*** *CANCER*

Y ***N*** *RADIATION OR COBALT TREATMENTS*

Y ***N*** *DIABETES*

Y ***N*** *EPILEPSY*

Y ***N*** *LUPUS*

Y ***N*** *LUNG DISEASE (TB, COPD, Asthma, Emphysema, etc.)*

Y ***N*** *KIDNEY DISEASE*

Y ***N*** *LIVER DISEASE*

Y ***N*** *ULCERS*

Y ***N*** *ARTHRITIS*

Y ***N*** *ASTHMA*

Y ***N*** *SINUS TROUBLE*

Y ***N*** *GLAUCOMA*

Y ***N*** *PSYCHIATRIC TREATMENT*

Y ***N*** *VENEREAL DISEASE*

Y ***N*** *SYPHILIS*

Y ***N*** *AIDS OR HIV+ (positive)*

Y ***N*** *HERPES*

Y ***N*** *ARE YOU PREGNANT?*

Y ***N*** *DO YOU TAKE ORAL CONTRACEPTIVES?*

Y ***N*** *STROKE OR HEART ATTACK*

Y ***N*** *ANEMIA (Sickle Cell, Low Iron)*

Y ***N*** *DO YOU CONSIDER YOUR MEDICAL HEALTH TO BE GOOD?*
WHEN WAS YOUR LAST MEDICAL CHECK-UP? _____

Y ***N*** *ARE YOU TAKING ANY MEDICATION (PRESCRIPTION OR NON-PRESCRIPTION) REGULARLY?*

PLEASE LIST;_____
_____

Y ***N*** *DO YOU NORMALLY TAKE ANTIBIOTICS PRIOR TO DENTAL TREATMENT?*

Y ***N*** *ARE YOU BEING TREATED BY A MEDICAL DOCTOR AT THIS TIME?*
FOR WHAT? _____

Y ***N*** *HAVE YOU EVER HAD AN INJURY TO YOUR FACE OR JAW?*

Y ***N*** *DO YOU SMOKE OR CHEW TOBACCO? HOW MUCH? _____*
WHAT TYPE? _____

Y ***N*** *ARE YOU TAKING BLOOD THINNERS, TRANQUILIZERS, OR AMPHETAMINES?*
IF YES, PLEASE SPECIFY _____

Y ***N*** *ARE YOU ALLERGIC TO OR REACT TO ANY MEDICINES OR DRUGS? (Penicillin, asprin, novocaine, etc.)*
IF YES, PLEASE EXPLAIN_____

Y ***N*** *DO YOU HAVE MULTIPLE ALLERGIES? (Latex, foods, etc)*

IF YES, PLEASE SPECIFY: _____

Y ***N*** *HAVE YOU BEEN HOSPITALIZED RECENTLY? WHY? _____*

WHEN? _____

NAME OF PHYSICIAN _____

PHONE # _____

DENTAL HISTORY

Y ***N*** *ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH?*

Y ***N*** *ARE YOUR GUMS RED, SWOLLEN OR TENDER?*

Y ***N*** *DO YOUR GUMS BLEED WHEN YOU BRUSH?*

Y ***N*** *ARE YOUR GUMS PULLING AWAY FROM YOUR TEETH?*

Y ***N*** *ARE YOU EXPERIENCING PAIN AND DISCOMFORT FROM YOUR MOUTH AT THIS TIME?*

Y ***N*** *HAVE YOU EVER HAD GUM (PERIODONTAL) TREATMENTS?*

Y ***N*** *ARE YOUR TEETH SENSITIVE TO HOT, COLD OR SWEETS?*

Y ***N*** *ARE YOU AWARE OF ANY CLENCHING OR GRINDING HABITS?*

Y ***N*** *DO YOU EVER HAVE PAIN OR POPPING IN YOUR EARS?*

Y ***N*** *IS THERE ANY CHANGE IN THE WAY YOUR TEETH FIT TOGETHER WHEN YOU BITE?*

Y ***N*** *HAVE YOU EVER WORN BRACES TO STRAITEN YOUR TEETH?*

Y ***N*** *DO YOU CHEW ON ONLY ONE SIDE OF YOUR MOUTH?*

*WHY?*_____

Y ***N*** *DO YOU HAVE HEADACHES REGULARLY?* _____*MORNING* _____ *NIGHT*

Y ***N*** *HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS IN THE PAST?*

Y ***N*** *DO YOU EVER HAVE CANKER SORES?*

Y ***N*** *HAVE YOU EVER HAD TREATMENT FOR TUMORS, GROWTHS, OR CANCER IN OR AROUND YOUR MOUTH?*

ACKNOWLEDGEMENT AND AUTHORIZATION FOR TREATMENT

I HEREBY AUTHORIZE THE DENTAL OFFICE TO ADMINISTER SUCH MEDICATIONS AND PERFORM SUCH DIAGNOSTIC AND THERAPEUTIC PROCEDURES AS MAY BE NECESSARY FOR PROPER CARE. THE INFORMATION ON THE PATIENT INFORMATION PAGE AND THE DENTAL/ MEDICAL HISTORIES ARE CORRECT TO THE BEST OF MY KNOWLEDGE. I GRANT THE RIGHT TO THE OFFICE TO RELEASE MY DENTAL/MEDICAL HISTORIES AND OTHER INFORMATION ABOUT MY CARE/TREATMENT TO THIRD PARTY PAYERS AND/OR OTHER HEALTH PROFESSIONALS.

I UNDERSTAND THAT IF A AM USING DENTAL INSURANCE IT IS A CONTRACT BETWEEN MYSELF AND THE INSURANCE COMPANY. IT IS MY RESPONSIBILITY, NOT THE RESPONSIBILITY OF THE OFFICE TO KNOW MY INDIVIDUAL DENTAL COVERAGE. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ALL COSTS OF TREATMENT, INCLUDING ANY FEES NOT PAID MY INSURANCE COMPANY. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO ADVANCED DENTAL CENTER ON THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

I UNDERSTAND THAT IF I DO NOT PAY MY ENTIRE NEW BALANCE WITHIN 30 DAYS OF THE MONTHLY BILLING DATE, A SERVICE CHARGE WILL BE ADDED TO MY ACCOUNT FOR THE CURRENT MONTHLY BILLING PERIOD. THE SERVICE CHARGE WILL BE A PERIODIC RATE OF 1% PER MONTH WHICH IS AN ANNUAL PERCENTAGE RATE OF 12% APPLIED TO THE LAST MONTH'S BALANCE. IN THE CASE OF DEFAULT OF PAYMENT, I PROMISE TO PAY ANY LEGAL INTEREST ON THE BALANCE DUE, TOGETHER WITH ANY COLLECTION COSTS AND REASONABLE ATTORNEY FEES INCURRED TO EFFECT THE COLLECTION OF THIS ACCOUNT ON FUTURE OUTSTANDING ACCOUNTS.

_____*Adult Patient* _____ *Father (or Husband)* _____*Mother (or Wife)* _____ *Guardian*

_____

Signature

_____ _____

Date State Driver's License #