GETTING TO KNOW YOU

Patient Name:	Social Security Number:	Home Phone:
Home Address :	Cell Phone:	May we send you text message? Yes No
City, State, Zip:		Status: Married Single Divorced Widow Child
Date of Birth:	Male Female	Email:
Occupation:	Employer:	Employer Phone Number:

Person Responsible for Account if other than yourself

Name:	Relationship:	Home Phone:
Address:	City, State, Zip:	Social Security Number:

Who referred you to our office:

MEDICAL HISTORY

Y	N	Heart Disease	Y	N	Heart Murmur/Mitral Valve Prolapse	Y	N	Stroke
Y	N	Congenital Heart Lesions	Y	N	Rheumatic Fever	Y	N	Abnormal Blood Pressure
Y	N	Anemia	Y	N	Prolonged Bleeding Disorder	Y	N	Tuberculosis or Lung Disease
Y	N	Asthma	Y	N	Hay Fever	Y	N	Sinus Trouble
Y	N	Epilepsy/Seizures	Y	N	Ulcers	Y	N	Artificial Joints
Y	N	Liver Disease	Y	N	Jaundice	Y	N	Hepatitis Type ______
Y	N	Diabetes	Y	N	Arthritis	Y	N	Infectious Mononucleosis (Mono)
Y	N	Herpes	Y	N	Tumor or Malignancy	Y	N	Sexually Transmitted Disease
Y	N	Kidney Disease	Y	N	History of Drug Addiction	Y	N	Cancer/Chemotherapy
Y	N	Radiation Treatment	Y	N	Pacemaker	Y	N	Stomach Problems
Y	N	Respiratory Problems	Y	N	Immune Suppressed Disorders/AIDS	Y	N	Fainting Spells
Y	N	Hearing Loss	Y	N	History of Emotional/Nervous Disorders			*Women*
Y	N	Glaucoma				Y	N	Birth control medication
Y	N	I have consumed alcohol within the last 24 hrs.				Y	N	Nursing or Pregnant

Y N I smoke or use tobacco. If yes, how much per day?_____ How many years? _____

Y N I have had major surgery: Year _________ Type ___________________ Year ________ Type ____________________

Y N I usually take antibiotic prior to dental treatment.

Y N Taking (please circle) Daily Aspirin Vitamin D Fish Oil Blood Thinner

Y N Do you have any other medical problem or medical history NOT listed on this form? ____

ALLERGIES

- Y N Aspirin
- Y N Ibuprofen
- Y N Sulfa Drugs/Sulfites/Sulfides
- Y N Penicillin/Amoxicillin
- Y N Codeine
- Y N Latex, Metals, Plastics
- Y N Local Anesthetics (Novacaine)
- Y N Other Medications – Which ones?

_______________ _______________

Medications (Prescribed/Over the counter

Y N Attached list of medications (if yes, no need to complete below)

Medicine ____________________________ Dosage_______________ Condition_____________________
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Medicine ____________________________ Dosage_______________ Condition_____________________

In Case Of Emergency please contact

Name:	Relationship:	Phone:
Name :	Relationship:	Phone:

Dental Coverage? Yes (please continue) No (skip to Authorization)

Dental Insurance Information Primary

Insurance Co. Name: **Group Name:** **Group Number:**

Insurance Co. Claim Address: **Street/PO Box:** **City, State, Zip:**

Subscriber's Name: **Social Security # or ID #** **Relationship:** **Date of Birth:**

Subscriber's Employer: **Employers Address:** **Street/PO Box** **City, State, Zip**

Dental Insurance Information Secondary (If applicable)

Insurance Co. Name: **Group Name:** **Group Number:**

Insurance Co. Claim Address: **Street/PO Box:** **City, State, Zip:**

Subscriber's Name: **Social Security # or ID #** **Relationship:** **Date of Birth:**

Subscriber's Employer: **Employers Address:** **Street/PO Box** **City, State, Zip**

Authorization

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

____

Signature Date

PAYMENT IS DUE AT TIME OF SERVICE

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I certify that I (or my child) have active dental coverage with the above listed insurance companies. I am authorizing the release of information concerning my (or my child's) dental care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

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Signature Date