FAMILY DENTAL ASSOCIATES

Welcome To Our Practice

PATIENT INFORMATION

Date _____

❍ Mr. ❍ Mrs. ❍ Ms. ❍ Dr. First Name _____ M.I. ____ Last Name _____ Nickname _____

Sex: ❍ Male ❍ Female Birth Date _____ Age _____ Soc. Sec. # _____ E-mail _____

Street _____ City _____ State _____ Zip _____

Home Tel. (_____) _____ Cell (_____) _____ Have you ever been a patient of our practice? ❍ Yes ❍ No

Medical Doctor _____ Referred by _____
FIRST NAME LAST NAME FIRST NAME LAST NAME

Driver's Lic. # _____ Nearest relative not living with you _____ Tel. (_____) _____
FIRST NAME LAST NAME

Employer _____ Bus. Tel. (_____) _____ Payment Type: ❍ Cash ❍ Check ❍ Credit Card

EMERGENCY CONTACT:

Name _____ Home Tel. (_____) _____ Bus. Tel. (_____) _____

Who will be responsible for your account?

❍ Self ❍ Spouse ❍ Father ❍ Mother ❍ Other _____

(If self, skip to next section)

Name _____ S.S. # _____ Birth Date _____ Age ____ Tel. (_____) _____
FIRST NAME LAST NAME

Street _____ City _____ State _____ Zip _____

Employer _____ Bus. Tel. (_____) _____

Spouse or other guarantor information *(if different from above)*

Name _____ Relation _____ S.S. # _____ Birth Date _____
FIRST NAME LAST NAME

Street _____ City _____ State _____ Zip _____

Tel. (_____) _____ Employer _____ Bus. Tel. (_____) _____

INSURANCE INFORMATION

Student: ❍ Full Time ❍ Part Time ❍ Not School Info _____
SCHOOL NAME ADDRESS

❍ Married ❍ Divorced ❍ Legally Separated ❍ Widow ❍ Single _____
CITY STATE ZIP

Employed: ❍ Full Time ❍ Part Time ❍ Retired ❍ Not Do you belong to a PPO or HMO? ❍ Yes ❍ No

PRIMARY DENTAL INSURANCE

Employer _____ Bus. Address _____
ADDRESS CITY STATE ZIP

Bus. Tel. (_____) _____ Plan _____ **Ins. Co. Name** _____

Address _____ Tel. (_____) _____
ADDRESS CITY STATE ZIP

Group # _____ **Group Name** _____ **Insured Party** _____ Relation _____
FIRST NAME LAST NAME

Sex: ❍ Male ❍ Female Birth Date _____ Address _____
CITY STATE ZIP

Tel. (_____) _____ S.S. # _____ I.D. # _____

SECONDARY DENTAL INSURANCE

Employer _____

Bus. Address _____
ADDRESS CITY STATE ZIP

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____

Address _____

_____ Tel. (_____) _____
CITY STATE ZIP

Group # _____ **Group Name** _____

Insured Party _____ Relation _____
FIRST NAME LAST NAME

Sex: ❍ Male ❍ Female Birth Date _____

_____
ADDRESS CITY STATE ZIP

Tel. (_____) _____ S.S. # _____

I.D. # _____

PRIMARY MEDICAL INSURANCE

Employer _____

Bus. Address _____
ADDRESS CITY STATE ZIP

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____

Address _____

_____ Tel. (_____) _____
CITY STATE ZIP

Group # _____ **Group Name** _____

Insured Party _____ Relation _____
FIRST NAME LAST NAME

Sex: ❍ Male ❍ Female Birth Date _____

_____
ADDRESS CITY STATE ZIP

Tel. (_____) _____ S.S. # _____

I.D. # _____

FAMILY DENTAL ASSOCIATES

Welcome To Our Practice

HEALTH HISTORY

To our patients: Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

- Have there been any changes in your general health in the past year? ❍ Yes ❍ No
- Are you under the care of a physician? ❍ Yes ❍ No Date of last visit _____
  If so, for what are you being treated? _____
- Have you had an illness, operation or been hospitalized in the past five years? ❍ Yes ❍ No
  If so, describe _____
- Do you have unhealed/recurrent injuries or inflamed areas, growths or sore spots in or around your mouth? ❍ Yes ❍ No
  If so, describe where _____
- Do you have a prosthetic joint/implant? *If so, describe where* _____
- Have you had a heart valve replacement or vascular graft? ❍ Yes ❍ No

HAVE YOU HAD OR DO YOU CURRENTLY HAVE...	Yes	No	Notes
Rheumatic fever?			
Damaged heart valves/mitral valve prolapse?			
Heart murmur?			
High blood pressure?			
Low blood pressure?			
Chest pain / angina?			
Heart attack(s)?			
Irregular heart beat?			
Cardiac pacemaker?			
Heart surgery?			
Stroke?			
Congenital heart disorder?			
Frequent headaches?			
Blood transfusion?			
Blood disorder such as anemia?			
Bruise easily?			
Bleeding tendency / abnormal bleed?			
Hepatitis, jaundice, or liver disease?			
Infectious mononucleosis?			
Osteoporosis / Osteopenia?			
Osteonecrosis?			
Stomach ulcers?			
Cortisone Medication?			
Thyroid trouble?			
Diabetes / excessive thirst?			
Low blood sugar?			
Kidney trouble?			
Are you on dialysis?			
Swollen ankles, arthritis or joint disease?			
Bronchitis, chronic cough?			
Asthma?			

HAVE YOU HAD OR DO YOU CURRENTLY HAVE...	Yes	No	Notes
Hay fever / sinus problems?			
Snoring / sleep apnea?			
Difficult breathing / other lung trouble?			
Tuberculosis?			
Emphysema?			
Anaphylaxis?			
Easily winded?			
A tumor or growth / cancer?			
Radiation therapy / chemotherapy?			
Chronic fatigue / night sweats?			
Contagious diseases?			
Sexually transmitted diseases?			
Are you immunosuppressed? possibly from transplant surgery, etc.			
Problems with the immune system? possibly from medication / surgery / AIDS / HIV, etc.			
Delay in healing?			
Cold sores / fever blisters?			
Gallbladder trouble?			
Fainting spells?			
Convulsions / epilepsy?			
Vertigo / dizziness?			
Contact lenses?			
Eye disease / glaucoma?			
Mental health problems?			
Pain and clicking of jaws when eating?			
Autism?			
ADD/ADHD?			
Alzheimer's disease?			
Do you smoke?			
Do you use chewing tobacco?			
A history of drug abuse?			
A history of alcohol abuse?			

MEDICATION - Are you now taking or have you taken...	Yes	No	Notes
Any kind of medication, drug, pills?			
Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko Biloba?			
Have you ever taken diet pills?			
Any natural product, herbal supplement or homeopathic remedy?			
Any bone density medications / Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)?			

Please list any medications you are currently taking:

ALLERGIES - Are you allergic to or had a reaction to...	Yes	No	Notes
Local anesthetic (numbing med.)?			
Penicillin?			
Other antibiotics?			
Sulfa drugs?			
Sodium pentothal, Valium, or other tranquilizers?			
Aspirin?			
Codeine or other narcotics?			
Other medications?			
Latex?			
Soy?			
Eggs / Yolk?			
Sulfites?			
Pine nut / peanut allergy?			
Acrylic?			
Metal?			

Please list any allergies other than drug allergies:

Is there any condition concerning your health that the Doctor should be told about?
❍ Yes ❍ No *(if yes, describe)*

Do you wish to speak to the doctor privately about anything? ❍ Yes ❍ No

THIS SECTION IS FOR WOMEN ONLY.

- Is there a possibility of pregnancy? ❍ Yes ❍ No
- Expected delivery date _____
- Are you nursing? ❍ Yes ❍ No
- Are you taking birth control pills? ❍ Yes ❍ No

Women Note: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

I certify that I have read and I understand the questions on this form. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: _____
(Parent or Guardian if minor)

Reviewed by: _____

Date: _____

FEES AND PAYMENTS

We make every effort to keep down the cost of your oral care. An **estimate** of the charge for any procedure will be given to you. As a courtesy, we will file any medical and/or dental claims. It is your responsibility to pay the coinsurance or any deductible that may apply, at time of service. Any claim not paid within 90 days will then become the patient's responsibility.

NO SHOW/CANCELLATION POLICY

We ask for our patients to provide at least a 24-hour notice for any appointment changes. Failure to do so will result in a $50 no show fee. Reoccurring missed appointments will result in being dismissed from our practice.

Signature of patient: _____ **Date:** _____
(Parent or Guardian if minor)

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of patient: _____ **Date:** _____
(Parent or Guardian if minor)

AUTHORIZATION

I authorize my dentist and his designated staff, to perform an oral and maxilofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

Witness: _____

Date: _____ **Signature of patient:** _____
(Parent or Guardian if minor)

Doctor: _____

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me.
I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of patient: _____ **Date:** _____
(Parent or Guardian if minor)

Thank you for providing this information. We appreciate being your dental provider.