ADVANCES IN DENTISTRY

PATIENT INFORMATION

Name_____ PREFERRED _____
Last First MI

Address_____ Home#_____

City_____ State_____ Zip_____ Cell# _____

Age_____ DOB____/___/____ Soc. Sec. # _____-_____-_____Work#_____

E-mail Address _____ Facebook User: Yes No

Male _____ Female _____ Marital Status: Single Married Divorced Widowed Child

Employer_____ Occupation _____

Whom may we thank for referring you? _____

In case of emergency who should we contact? _____ Phone # _____

How would you like to be notified of appointments? (circle) EMAIL TEXT PHONE

PRIMARY DENTAL INSURANCE INFORMATION

Subscriber (member)_____ Subscriber SS#_____-_____-_____

Subscriber DOB _____/_____/_____ Relationship to Patient_____

Subscriber Employer_____ Business Phone _____

Insurance Co. _____ Group#_____ Ins. Phone#_____

DENTAL HISTORY

Reason for today's visit_____ Date of last dental care_____
Former Dentist_____ Date of last dental x-rays_____
Have you ever or are currently having any problems with the following:

____Sensitivity to sweets	____Bite sensitivity	____Sores or growths
____Clicking or popping jaw	____Sensitivity to hot/cold	____Grinding teeth
____Loose teeth/broke fillings	____Bleeding gums	____Food Collection
____Missing Teeth	____Loose Dentures	____Bad Taste in Mouth

Pain Scale: (mark X) mild ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ severe
0 1 2 3 4 5 6 7 8 9 10

How often do you floss?_____ How often do you brush?_____
Are you happy with: Your smile_____ Color of teeth_____ Alignment of teeth_____
What would you change about your smile? _____
Do you want Nitrous Oxide (Laughing Gas)? Yes_____ No _____

MEDICAL HISTORY

Physician's Name_____ Phone Number _____
Date of last medical care_____ Reason _____
Have you ever taken any of the group of weight loss drugs collectively referred to as "fen-phen"?
(Including combinations of Lonimin, Adipex, Fastin, Pondimin and Redux) Yes_____ No_____
Have you ever taken Fosamax or Boniva? Yes ____ No _____
Have you had any serious illnesses or operations? Yes_____ No_____ Date _____
Describe_____

Have you ever had a blood transfusion? Yes_____No_____ Approximate dates_____

WOMEN: Pregnant? Yes___No___ Due Date _____ Nursing? Yes___No___ Birth control? Yes___No___

Circle if you have had or have any of the following:

Allergies	Diabetes	High Blood Pressure	Scarlet Fever
Anemia	Dizziness	HIV/Aids	Shortness of Breath
Arthritis	Epilepsy (Seizures)	Jaundice	Sinus Problems
Artificial Heart Valves	Excessive Bleeding	Jaw Pain	Skin Rash
Artificial Joints	Extremely Nervous	Kidney Disease	Stroke
Asthma	Fainting	Liver Disease	Stomach Problems
Back Problems	Glaucoma	Mental Disorders	Sulfa Drug Allergy
Blood Disease	Growths	Mitral Valve Prolapse	Swelling of Feet/Ankles
Cancer	Hay Fever	Nervous Disorders	Thyroid Problems
Chemical Dependency	Headaches	No Epinephrine	Tobacco Habit
Chemotherapy	Head Injuries	Pacemaker	Tonsillitis
Circulatory Problems	Heart Disease	Penicillin Allergy	Tuberculosis
Codeine Allergy	Heart Murmur	Radiation Treatment	Tumors
Cortisone Treatments	Heart Problems	Respiratory Disease	Ulcer
Cough (Persistent)	Hemophilia	Rheumatic Fever	Venereal Disease
Coughing up blood	Hepatitis A B C	Rheumatism	Other:

Medications (list Medications you are currently taking with reason) **Allergies:**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Have you ever been advised to pre-medicate prior to a dental appointment? Yes No
Are you currently taking any blood thinners such as Aspirin, Plavix, Coumadin, etc? Yes No

AUTHORIZATION AND CONSENT FOR SERVICES

I acknowledge that I understand the Patient Privacy Notice and have been given a copy of my rights if requested. I authorize my insurance company (if applicable) to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I authorize the dentist to release all health information necessary to secure the payment for benefits. In addition, Advances in Dentistry may share my health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other healthcare personnel providing your treatment. I understand that I am financially responsible for all charges whether or not paid by my insurance. Additionally, I understand that I will be given a *guesstimate* for services due in advance of insurance payment. If insurance does not pay as much as expected, I understand that I am responsible for the remaining payment in a timely manner. I have made the doctor aware of all medical conditions and drug allergies past and present and realize that there are risks involved with dental procedures. I understand that it may be recommended for me to consent with my medical physician before proceeding with treatment due to past/present medical conditions. *I also understand that if I cancel without giving 48 hours or do not show up to my appointment, I will be charged a minimum fee of $35 up to 15% of my scheduled appointment fee.* **Payment is due in full at time of treatment unless prior arrangements have been approved.**

_____ Date_____
Print Patient Name

_____
Patient or Legal Guardian Signature