

ADVANCES IN DENTISTRY

PATIENT INFORMATION

Name _____ Last First MI PREFERRED _____

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 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 severe

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