ASSOCIATED FAMILY DENTISTRY

MR.☐ MRS.☐ DR.☐ MS.☐

MARITAL STATUS: _____

NAME: _____

NICKNAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

HOME PHONE: _____

WORK PHONE: _____ EXT: _____

CELL PHONE: _____

BIRTHDATE: _____ SEX: _____

TODAY'S DATE: _____

SOCIAL SECURITY #: _____-_____-_____

SPOUSE'S NAME: _____

IF PATIENT IS A FULL TIME STUDENT

SCHOOL: _____ CITY: _____

EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

HOW WERE YOU REFERED TO OUR OFFICE? _____

IF PATIENT, NAME PLEASE: _____

NAME AND ADDRESS OF NEAREST RELATIVE NOT LIVING WITH YOU: _____

_____ PHONE: _____

GUARANTOR INFORMATION: (*PERSON RESPONSIBLE FOR ACCOUNT*) # _____

MR.☐ MRS.☐ DR.☐ MS.☐ Relationship to patient:_____

NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

HOME PHONE: _____

EMPLOYER: _____

ADDRESS: _____

SOCIAL SECURITY #: _____-_____-_____

BIRTHDATE: _____ SEX: _____

WORK PHONE: _____ EXT: _____

CELL PHONE: _____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INSURED'S NAME: (*Employee*) _____

BIRTHDATE: _____

GROUP #: _____

SOCIAL SECURITY #: _____-_____-_____

EMPLOYER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____

SECONDARY INSURANCE COMPANY: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INSURED'S NAME: (*Employee*): _____

BIRTHDATE: _____

GROUP #: _____

SOCIAL SECURITY #: _____-_____-_____

EMPLOYER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____

The undersigned persons represent that all the above statements are true and complete and hereby authorize verification of such information and a background credit check for the purpose of granting me credit, if applicable.

*** The financial responsibility for services rendered rests totally with the patient or guarantor regardless of any insurance coverage. Payment is due in full when services are rendered unless arrangements have been make prior to seeing the doctor. There will be a finance charge of 1.5% per month or 18% annually imposed on all unpaid balances.

I also agree to pay for court costs and attorney fees if my account is litigated.

_____

Signature of person responsible for account

MEDICAL HISTORY

ASA # 1 2 3 4 5

Patient: _____

Family Physician: _____ Physician's Telephone: _____

1. Are you having pain or discomfort at this time?.....YES NO
2. Do you feel nervous about having dentistry treatment?.....YES NO
3. Have you ever had a bad experience in the dentist's office?.....YES NO
4. Have you been a patient in the hospital during the past two years?.....YES NO
5. Have you been under the care of a medical doctor during the past two years?.....YES NO
6. Are you taking medicine, drugs or herbal supplements regularly?.....YES NO
   If so, PLEASE LIST: _____
7. Are you ALLERGIC to, or had a reaction to ANY of the following: metal jewelry, Latex, Iodine, Sulfa, Penicillin, Erythromycin, Keflex, Asprin, Codeine, or any other medications (including local anesthetic) not listed above?.....YES NO
   If so, PLEASE LIST: _____
8. Have you ever had any clotting/excessive bleeding problems requiring special treatment?.....YES NO
9. Please circle YES or NO regarding the following conditions.

Y / N Heart Failure	Y / N Kidney Trouble	Y / N AIDS / HIV
Y / N Heart Disease / Attack	Y / N Ulcers	Y / N Hepatitis _____
Y / N Heart Murmur	Y / N Emphysema	Y / N Liver Disease
Y / N Mitral Valve Prolapse	Y / N Persistent Cough	Y / N Yellow Jaundice
Y / N Rheumatic Fever	Y / N Tuberculosis (TB)	Y / N Blood Transfusion
Y / N Heart Pacemaker	Y / N Hay Fever	Y / N Pain in Jaw Joints
Y / N Heart Surgery	Y / N Sinus Trouble	Y / N Drug / Alcohol Addiction
Y / N High Blood Pressure	Y / N Allergies or Hives	Y / N Anemia
Y / N Angina Pectoris	Y / N Asthma	Y / N Bruises Easily
Y / N Congenital Heart Lesions	Y / N Cortisone Medicine	Y / N Hemophilia
Y / N Artificial Heart Valve	Y / N Cold Sores	Y / N Sickle Cell Disease
Y / N Artificial Joint	Y / N Diabetes	Y / N Venereal Disease
Y / N Arthritis	Y / N Thyroid Disease	Y / N Fainting / Dizzy Spells
Y / N Stroke	Y / N Radiation Therapy	Y / N Epilepsy or Seizures
Y / N Glaucoma	Y / N Chemotherapy	Y / N Nervousness
Y / N Scarlet Fever	Y / N (Cancer, Leukemia)	Y / N Psychiatric Treatment
Y / N OTHER _____	Y / N OTHER _____	Y / N OTHER _____

10. Have you taken Phen-Fen or Redux?.....YES NO
11. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired?.....YES NO
12. Do your ankles swell during the day?.....YES NO
13. Do you use more than 2 pillows to sleep?.....YES NO
14. Have you lost or gained more than 10 pounds in the past year?.....YES NO
15. Do you ever wake up from sleep short of breath?.....YES NO
16. Has your medical doctor ever said you have a tumor or cancer?.....YES NO
17. Do you have any disease, condition or problem not listed?.....YES NO
18. WOMEN: Are you pregnant now?.....YES NO
    Are you breast feeding?.....YES NO
19. Date of last dental visit? _____
20. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? If so, when? _____
21. Is there anything about the appearance of your teeth you would like to change?.....YES NO
    If so, what? _____
22. Antibiotics that may be prescribed in this office could possibly reduce the effectiveness of oral contraceptives.

To the best of my knowledge, all the preceding answers are true and correct. If there is any change in my health, or if my medications change, I will inform the doctor at the next appointment.

_____ _____

Date Signature of patient, parent or guardian