Welcome

Thank you for selecting our dental heatchcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Paula Stewart DMD
FAMILY DENTAL CENTER

Patient Information (confidential)

Name_____ Birthday_____ Home Phone_____

SS#/SIN_____ Date_____ Patient's Sex ___F ___M

Address_____ City_____ State_____ Zip_____

Email_____ Cell Phone_____

Do you prefer to receive calls at your: ___Home ___Work ___Cell

Check Appropriate: ___Minor ___Single ___Married ___Divorced ___Widowed ___Separated

If Student, Name of School/College_____ City_____ State_____ Full Time Part Time

Patient or Parent/Guardian's Employer_____ Work Phone_____

Business Address_____ City_____ State_____ Zip_____

Spouse or Parent/Guardian's Name_____ Employer_____ Work Phone_____

Whom May We Thank for Referring You?_____

Person to Contact in Case of Emergency_____

Responsible Party

Name of Person Responsible for this Account_____ Relationship to Patient_____

Address_____ Home Phone_____

Email_____ Cell Phone_____

Driver License #_____ Birthdate_____ Financial Institution_____

Employer_____ Work Phone_____ SS#/SIN_____

Is this Person Currently a Patient in our Office? ___Yes ___No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

___Cash ___Personal Check ___Credit Card ___Visa ___MasterCard ___I wish to discuss the office's payment policy.

Insurance Information

Name of Insured_____ Relationship to Patient_____

Birthdate_____ SS#/SIN_____ Date Employed_____

Name of Employer_____ Union or Local #_____ Work Phone_____

Address of Employer_____ City_____ State_____ Zip_____

Insurance Company_____ Group #_____ Policy/ID #_____

Ins. Co. Address_____ City_____ State_____ Zip_____

How Much is your Deductible?_____ How Much Have You Used?_____ Max. Annual Benefit_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ___YES ___NO If yes, complete the following:

Name of Insured_____ Relationship to Patient_____

Birthdate_____ SS#/SIN_____ Date Employed_____

Name of Employer_____ Union or Local #_____ Work Phone_____

Address of Employer_____ City_____ State_____ Zip_____

Insurance Company_____ Group #_____ Policy/ID #_____

Ins. Co. Address_____ City_____ State_____ Zip_____

How Much is your Deductible?_____ How Much Have You Used?_____ Max. Annual Benefit_____

Patient Medical History

Physician_____ Office Phone_____ Date of Last Exam_____

	yes	no
1. Are you under medical treatment now?	( )	( )
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	( )	( )
If yes, please explain_____		
3. Are you taking any medication(s) including non-prescription medicine?	( )	( )
If yes, what medications are you taking?_____		
4. Have you ever taken Fen-Phen/Redux	( )	( )
5. Have you ever taken Fosamax (alendronate), Boniva (ibandronate), Actonel (risedronate) or any cancer medications contaning bisposphonates?	( )	( )
6. Have you taken Viagra, Revatio (sildenafil), Cialis (tadalafil) or Levitra (vardenafil) in the last 24 hours?	( )	( )
7. Do you use tobacco?	( )	( )
8. Do you use controlled substances?	( )	( )
9. Do you have or have you had any of the following?		
10. Are you wearing contact lenses?	( )	( )
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	( )	( )
Penicillin or any other Antibiotics	( )	( )
Barbiturates	( )	( )
Sedatives	( )	( )
Iodine	( )	( )
Aspirin	( )	( )
Any Metals (e.g. nickel, mercury, etc.)	( )	( )
Latex Rubber	( )	( )
Other (please list)	( )	( )
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	( )	( )
13. Women Only:		
a.) Are you pregnant or think you may be pregnant?	( )	( )
b.) Are you nursing?	( )	( )
c.) Are you taking oral contraceptives?	( )	( )

	yes	no		yes	no		yes	no
High Blood Pressure	( )	( )	Heart Disease	( )	( )	Chest Pains	( )	( )
Heart Attack	( )	( )	Cardiac Pacemaker	( )	( )	Easily Winded	( )	( )
Rheumatic Fever	( )	( )	Heart Murmur	( )	( )	Stroke	( )	( )
Swollen Ankles	( )	( )	Angina	( )	( )	Hay Fever / Allergies	( )	( )
Fainting / Seizures	( )	( )	Frequently Tired	( )	( )	Tuberculosis	( )	( )
Asthma	( )	( )	Anemia	( )	( )	Radiation Therapy	( )	( )
Low Blood Pressure	( )	( )	Emphysema	( )	( )	Glaucoma	( )	( )
Epilepsy / Convulsions	( )	( )	Cancer	( )	( )	Recent Weight Loss	( )	( )
Leukemia	( )	( )	Arthritis	( )	( )	Liver Disease	( )	( )
Diabetes	( )	( )	Joint Replacement or Implant	( )	( )	Heart Trouble	( )	( )
Kidney Diseases	( )	( )	Hepatitis / Jaundice	( )	( )	Respiratory Problems	( )	( )
AIDS or HIV Infection	( )	( )	Sexually Transmitted Disease	( )	( )	Mitral Valve Prolapse	( )	( )
Thyroid Problem	( )	( )	Stomach Troubles / Ulcers	( )	( )	Other _____		

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam_____

	yes	no
1. Do your gums bleed while brushing or flossing?	( )	( )
2. Are your teeth sensitive to hot or cold liquids/floods?	( )	( )
3. Are your teeth sensitive to sweet or sour liquids/foods?	( )	( )
4. Do you feel pain to any of your teeth?	( )	( )
5. Do you have any sores or lumps in your or near your mouth?	( )	( )
6. Have you had any head, neck, or jaw injuries?	( )	( )
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	( )	( )
Pain (joint, ear, side of face)	( )	( )
Difficulty in opening or closing	( )	( )
Difficulty in chewing	( )	( )
8. Do you have frequent headaches?	( )	( )
9. Do you clench or grind your teeth?	( )	( )
10. Do you bite your lips or cheeks frequently?	( )	( )
11. Have you ever had any difficult extractions in the past?	( )	( )
12. Have you had any prolonged bleeding following extractions?	( )	( )
13. Have you had any orthodontic treatment?	( )	( )
14. Do you wear dentures or partials?	( )	( )
If yes, date of placement _____		
15. Have you ever recieved oral hygiene instructions regarding the care of your teeth and gums?	( )	( )
16. Do you like your smile?	( )	( )

Authorization and Release

Payment is due in full at the time of treatment unless prior arrangements have been made.
This office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all cost of dental treatment. I herby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.
I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information 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 any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature of patient (or parent/guardian if minor) Date