Family Dental Associates

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PATENT INFORMATION

Patient's Name_____Birthdate_____Telephone_____
Address_____ City_____State_____Zip_____
Social Security #_____ E-mail_____
Employer_____ Business Phone_____
Occupation_____ Cell Phone_____ M or F_____

Primary Subscriber's Name_____ Social Security #_____
Primary Insurance Name_____ Group #_____ Birthdate_____
Secondary Subscriber's Name_____ Social Security #_____
Secondary Insurance Name_____ Group #_____ Birthdate_____

SPOUSE OR GUARDIAN INFORMATION

Name_____ Birthdate_____ Telephone_____
Address_____City_____State_____Zip_____
Employer_____ Occupation_____ Social Security #_____

In order to render effective dental treatment a thorough examination, diagnosis and treatment plan will be necessary before routine dental treatment is started.

Purpose of Appointment _____ Referred by_____

In case of emergency, who can we contact if a spouse or guardian is unreachable?

Name _____ Phone _____ Relationship_____

DENTAL HEALTH INFORMATION

(Answer these questions as they apply to you)

1.Approximate date of your last dental visit? _____ Previous Dentist's Name _____

	YES	NO
2. Approximate date of your last dental x-rays?_____		
3. Have you ever had a reaction to a local anesthetic (novocaine)?……	☐	☐
4. Have you ever experienced any unfavorable dental treatment? ……	☐	☐
5. Do heat, cold or sweets cause pain in your teeth? ……..	☐	☐
6. Are you aware or have you been made aware of clenching/grinding of your teeth? …….	☐	☐
7. Have you ever seen a dental specialist (orthodontist, periodontist, oral surgeon, endodontist)?……	☐	☐

8. What do you think of your teeth?_____

GENERAL HEALTH INFORMATION

DO YOU HAVE A HISTORY OF:	YES	NO
1. Prolong bleeding…….	☐	☐
2. Prosthetic implants (joints, heart valves, breast, hip, knee, etc)…….	☐	☐
3. Glaucoma……..	☐	☐
4. Fainting or dizziness……...	☐	☐
5. Ill effects from Penicillin……...	☐	☐
6. Ill effects from drugs or medications…..	☐	☐
7. Rheumatic fever……..	☐	☐
8. Diabetes……..	☐	☐
9. Asthma…….....	☐	☐
10. Allergy (other than seasonal)……	☐	☐
11. Epilepsy……...	☐	☐
12. Lung disease (emphysema, tuberculosis)	☐	☐
13. Chemotherapy…….	☐	☐
14. Kidney disorder..…….	☐	☐
15. Liver disorder (hepatitis, jaundice, etc) …….	☐	☐
16. Thyroid disorder ……..……..….	☐	☐
17. Cancer……..……..	☐	☐
18. HIV carrier…….….	☐	☐
19. Cardiovascular disease (stroke, heart attack. high blood pressure, heart murmur, etc.)…….	☐	☐
20. Pacemaker……...	☐	☐
21. Radiation Treatment (other than diagnostic) ..	☐	☐
22. History of taking bisphosphonates …… (Zometa, Boniva, Aredia, Fosamax, Actenol)	☐	☐

23. Have you suffered from or been treated for drug or alcohol dependency? …….	☐	☐
24. Have any wounds healed slowly or presented other complications?……...	☐	☐
25. Are you pregnant? ……...	☐	☐
26. Have you seen your primary care physician in the last two years?…….	☐	☐
27. Have you been hospitalized?……	☐	☐
28. Do you use tobacco products?……..…	☐	☐

29. List and explain fully any other conditions which you feel might be of importance _____

_____

30. Are you now taking any drugs or medications?……...	☐	☐

If yes, please list medications _____

_____

NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGEMENT

We keep records of the health care services we provide you. You may ask to see and receive a copy of that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Dr. Peter Grieser. Our notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

I hereby authorize Dr. Grieser, Dr. Sullivan and/or Dr. Yoder to furnish information to insurance carriers concerning my Dental treatment and assign all payments for services rendered to my dependants or myself. I understand that I am responsible for any amount not covered by insurance. YES ☐ NO ☐

I hereby consent to receive Dental treatment at Family Dental Associates. YES ☐ NO ☐

I hereby give permission for Family Dental Associates to discuss treatment with my parents or spouse. YES ☐ NO ☐

I hereby give Family Dental Associates consent to leave voice mail messages regarding my dental appointment. YES ☐ NO ☐

I also agree that all information on both sides of this form is truthful and has been provided to the best of my knowledge.

Date_____ Signature_____

Update Medical History:

Date Signature

_____

_____