ADVANCED CARE DENTAL CENTER

Cosmetic, Family & Implant Dentistry

About You

Today's Date: _____

Patient Name: _____
Last First MI Mr. Mrs. Ms. Dr.

I like to be called: _____ ☐ Male ☐ Female

Birthdate: ___/___/___ Age: _____ SS#: _____

Whom may we thank for referring?

Referred by: _____

Responsible Person for Patient

Name: _____
Last First MI Mr. Mrs. Ms. Dr.

Home Address: _____
Apt/Condo #

_____
City State Zip

How long at this address:_____ Relation to patient: _____

Home #: _____

Cell #: _____

Work #: _____ Ext._____ SS#: _____

Email : _____

Birthdate:_____/_____/_____ DL#_____

Employer/Self-Employment:_____

Employer's Address: _____

No. years of employment:_____ Occupation:_____

Other Family Members

	NAME	AGE
Spouse		
Children		

Payment or Co-payment is due in full at the time of treatment

unless prior arrangements have been approved.

Method of Payment:

- ☐ Cash
- ☐ Visa or Mastercard
- ☐ Dental insurance & co-payment
- ☐ Other health care financial support
- ☐ Medical coupons

Dental Insurance

PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's SS#: _____

Insured's Employer: _____

Insured's Address: _____

MEDICAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's SS#: _____

Insured's Employer: _____

Today's visit is for:

_____

_____

_____

Medicine taken: _____

In the event of an emergency, is there someone that we should contact?

His/Her Name: _____ Relation: _____

Work #: _____ Home #: _____

Medical History

Your current physical health is: ☐ **Good** ☐ **Fair** ☐ **Poor**

Are you curently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Are you taking any prescription/over-the-counter drugs? ☐ Yes ☐ No

Please list each one: _____

For Women: *Are you taking birth control pills?* ☐ *Yes* ☐ *No*

Are you pregnant? ☐ *Yes* ☐ *No* *Week #:* _____

Are you nursing? ☐ *Yes* ☐ *No*

Have you ever had any of the following deseases or medical problems

Y N Anemia / Radiation Treatment
Y N Artificial Bones / Joints
Y N Artificial Valves
Y N Asthma / Arthritis
Y N Blood Transfusion
Y N Cancer / Chemotherapy
Y N Congenital Heart Defect
Y N Diabetes / Tuberculosis (TB)
Y N Difficulty Breathing
Y N Drug / Alcohol Abuse
Y N Emphysema / Glaucoma
Y N Epilepsy/Seizures/Fainting Spells
Y N Fever Blisters / Herpes
Y N Heart Attack / Stroke
Y N Heart Murmur
Y N Heart Surgery / Pacemaker
Y N Hemophilia/Abnormal Bleeding
Y N Hepatitis
Y N High / Low Blood Pressure
Y N HIV+ / AIDS
Y N Hospitalized for any reason
Y N Kidney Problems
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Rheumatic / Scarlet Fever
Y N Severe / Frequent Headaches
Y N Sinus Problems
Y N Ulcers / Colitis
Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y N Aspirin
Y N Codeine
Y N Local Anesthetics
Y N Erythromycin
Y N Latex, Rubber
Y N Penicillin
Y N Tetracycline
Y N Oher

Please list any other drugs that you are allergic to: _____

_____

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: _____ Date of last visit: _____

Dental History

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐Y ☐N Do your gums ever bleed? ☐Y ☐N

How many times a week do you floss? _____ a day do you brush? _____

Type of brushes? ☐ Hard ☐ Medium ☐ Soft

How long do you use a toothbrush before replacing it? _____

Are your teeth sensitive to heat, cold, or anything else? _____

Have you lost any teeth? ☐ Yes ☐ No If yes, why? _____

Previous/Present Dentist: _____

Phone #: _____ Location: _____

Last Cleaning Date: _____

Last Thorough Exam Date: _____

Comments: _____

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any change in my medical status, change of address, and phone number.

I consent to treatment and I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

_____
Signature Date

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any question at any time, please ask us. We are happy to help.

Our office is committed to meeting or exceeding the standard of infection control mandated by OSHA, the WISHA and the ADA.

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Reviewed with_____ Date:_____

Doctor's Comments: _____

_____

MEDICAL HISTORY UPDATE

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date