Patient Information

Patient Name_____ **Date**_____
Last First MI Preferred Name

Gender (M/F)_____ **Marital Status:**_____ **Birth Date:**_____ **Social Security :**_____

Address_____
Street Apartment #

_____
City State Zip Code

Phone #'s: **Home**_____ **Work**_____ **Ext**_____ **Best Time to Call**_____

Cell_____ **Fax**_____ **Pager**_____ **Other**_____

E-Mail Address: _____

Spouse or Responsible Party Information

Name_____ **Date**_____
Last First MI Preferred Name

Gender (M/F)_____ **Marital Status:** _____ **Birth Date:** _____ **Social Security #:** _____

Address_____
Street Apartment #

_____
City State Zip Code

Phone #'s: **Home**_____ **Work**_____ **Ext**_____ **Best Time to Call**_____

Cell_____ **Fax**_____ **Pager**_____ **Other**_____

Referral Information

Name of Person, Office or Other Source Referring you to our Practice:_____

Is Another Family Member or Relative a Patient at our Office: _____

Employment Information

The following is for: ☐ **Patient or,** ☐ **The person responsible for payment**

Employer Name:_____ **Phone #:** _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Name of Insured:_____ **Patient's Relationship to Insured:** ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

Insured's Birth Date:_____ **ID #:** _____ **Group #:** _____

Insured's Address:_____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Insurance Plan Name: _____ **Phone #**_____

Address: _____
Street City State Zip Code

Secondary

Name of Insured:_____ **Patient's Relationship to Insured:** ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

Insured's Birth Date:_____ **ID #:** _____ **Group #:** _____

Insured's Address:_____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Insurance Plan Name: _____ **Phone #**_____

Address: _____
Street City State Zip Code

Health Information

Physician's Name: _____ **Phone #:** _____

Address: _____ **Date of Last Physical Exam:** _____
Street City State Zip Code

Are you under a Physician's care at this time:_____ **If so, please describe**_____

Have you had any serious illnesses, operations or hospitalizations? If so, describe _____

Please answer all questions by circling YES (Y) or NO (N)—If YES, please circle appropriate item

Are you in good health	Y	N	Rheumatic Fever/Rheumatic Heart Disease	Y	N
Congenital Heart Disease	Y	N	Heart Trouble, Attack, Murmur, Artery Disease, Angina	Y	N
Implants (Heart Valve, Hip, Knee)	Y	N	Radiation (x-ray) Treatment for Cancer	Y	N
High Blood Pressure, Stroke	Y	N	Heart Palpitations, Surgery, Pacemaker, Chest Pain	Y	N
Seizures, Convulsions, Epilepsy	Y	N	Fainting, Dizziness, Nervous Disorder or Breakdown	Y	N
Bleeding Disorder, Anemia	Y	N	Blood Transfusion, Severe Bleeding, Bruise Easily	Y	N
Liver Disease (Jaundice, Hepatitis)	Y	N	Arthritis, Rheumatoid Arthritis	Y	N
Kidney Disease	Y	N	Stomach Ulcers, Colitis, GERD	Y	N
Diabetes	Y	N	Thyroid Disease (Goiter)	Y	N
Glaucoma	Y	N	Sinus or Nasal Problems	Y	N
Depressed Immune System	Y	N	Recurrent Infections of any kind	Y	N
Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, TB, Shortness of Breath)				Y	N
Do you Smoke or Chew Tobacco	Y	N	Do you use Alcohol	Y	N

Are you Using or Taking any of the Following:---If YES, please circle appropriate item

Tagamet, Prilosec or Nexium	Y	N	Thyroid Medications	Y	N
Antibiotics or Sulfa Drugs	Y	N	Anticoagulants (Blood Thinners)	Y	N
High Blood Pressure Medication	Y	N	Steroids (Cortisone, Etc.)	Y	N
Tranquilizers (Valium, Etc)	Y	N	Insulin, Diabetnese, or Similar Drug	Y	N
Ibuprofen (Motrin, Naproxyn, Etc)	Y	N How Much____	Digitalis, Inderal, Nitroglycerin Procardia	Y	N
Marijuana or Other Street Drugs	Y	N	Calcium Channel Blockers or other Heart Medicine	Y	N
Antihistamines or Decongestants	Y	N	Other Medications or Drugs	Y	N
Bisphosphonates Coralor I.V. for Osteoporosis	Y	N	If So, Please List_____		

Are you Allergic or Had a Bad Reaction To:---If YES, please circle appropriate item

Local Anesthetic (Novacaine, Etc)	Y	N	Penicillin, Amoxicillin, or Other Antibiotics	Y	N
Barbituates, Sedatives, Etc.	Y	N	Aspirin or Ibuprofen	Y	N
Codeine or Other Pain Killers	Y	N	Latex or Rubber Products	Y	N
Other Allergies or Reactions	Y	N If So, Please List _____			

Do you have any other disease, condition or problem not listed above that you think the Dentist should know about? Y N
Do you wish to talk with the Dentist privately about anything? Y N

For Women Only:
If you are using Oral Contraceptives it is important that you understand that Antibiotics and other medications may interfere with the effectiveness of Oral Contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills after the course of antibiotics or other medications is completed. Please consult with your Physician or further guidance. If you are Pregnant, possibly Pregnant or trying to become Pregnant, Surgery, Anesthetics or any other medication may significantly harm your developing baby, especially during the first trimester. Please advise your Doctor if there is any chance.

Dental Health Information

Date of Last Dental Exam _____

Do You Have or Have Had:

Recurring Mouth Sores	Y	N	Clicking or Popping Jaw Joint, Pain Near Ear	Y	N
Difficulty Opening Mouth	Y	N	Grinding or Clenching Teeth	Y	N

When I think about coming to the Dentist I Feel:
_____ **Comfortable (I have no anxiety about seeing the dentist or dental procedures)**
_____ **Anxious (I don't want to come but, I make myself, however, I am seldom comfortable)**
_____ **Fearful (I have stayed away from the dentist because of my fear and avoid coming unless absolutely necessary)**
_____ **Extremely Fearful (I cannot cope with dental visits and have avoided the dentist for years to the detriment of my dental health)**

I have avoided the dentist because of:
_____ **My anxiety and fear**
_____ **Past Experiences**
_____ **Cost**
_____ **No time**
_____ **Lack of trust**
_____ **Other** _____

My Childhood Dental Experiences Were:

_____ Completely pain free and comfortable
_____ Painful
_____ I did not go to the dentist as a child
_____ Somewhat uncomfortable
_____ Traumatic

I Have a Fear of – I have Concerns About:

_____ Experiencing pain
_____ Needles
_____ Gagging
_____ Having something put over my mouth
_____ Catching a disease
_____ Have to wear a denture or partial
_____ Not being numb
_____ Unnecessary or wrong treatment
_____ Losing control
_____ Being scolded or made to feel ashamed
_____ Losing my teeth
_____ Other _____

The Following Makes Me Uncomfortable:

_____ The sounds of a dental drill
_____ The smells in a dental office
_____ Having to wait in the reception area
_____ Laying down in a dental chair
_____ Being numb
_____ Other _____

To Understand What's Going on in my Mouth, my Preference is:

_____ To know all the details
_____ To be shown pictures and movies
_____ To talk with a team member about solutions to my problems
_____ To be given the bottom line
_____ To read pamphlets and brochures

My Immediate Concern About My Teeth and My Smile Is:

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient or Parent Signature _____

CONSENT:
The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with patient. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor chooses and employs such assistance as deemed fit to provide recommended treatment. Lastly, I understand that all responsibility for payment for dental services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates. I understand that a 1-½% finance charge (18% APR) may be added to my account.

Patient or Responsible Party Signature _____

CONSENT FOR RELEASE OF MEDICAL RECORDS

I hereby authorize Advanced Dental Associates to use and disclose my entire medical record in accordance with the Notice of Privacy Practices (NOPP). I have reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. I release, hold harmless and agree to indemnify Advanced Dental Associates, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this consent. I specifically authorize the practice to use and disclose verbally, by mail, fax or encrypted e-mail, confidential information as stated in the NOPP.

Patient or Responsible Party Signature _____