Paynesville Family Dental

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Welcome to our office…

In order to provide proper treatment, we will need the following information. All information is confidential.

PATIENT INFORMATION:

Patient____

Last *First* *M.I.* *Preferred Name/Nickname*

Address______________________________________City______________________ Zip________

Cell Phone____________________ Home Phone___________________ Birthdate________________

Text Confirmations: YES/NO ? (please circle one)

Email____ Sex: M F Age______________

Parent(s) or Guardian (if patient is under 18)____

In Case of emergency, contact__________________________________Phone_____________________

Relationship to patient__________________________________

INSURANCE INFORMATION: ***Any Changes to Dental insurance since last visit? YES/NO***

(If yes, fill out information below. If no, do not fill out)

Policy Holder Name:_____________________________ Birth Date of policy holder_________________

Dental Insurance Company:________________________________ Employer______________________

Subscriber ID:____________________________ Relationship to Policy Holder_____________________

Group #:________________________________

Please list all family members included under plan and relationship to policy holder:

__________________________________ ________________________________

__________________________________ ________________________________

__________________________________ ________________________________

Secondary Insurance: Yes No *If yes, please present card

(PLEASE FILL OUT BOTH SIDES OF THIS FORM)

PATIENT MEDICAL HISTORY

Please answer *EACH* question. Thank you.
Do you have, or have you ever had any of the following?

Yes / No Penicillin allergy
Yes / No Sulfa allergy
Yes / No Local anesthesia allergy
Yes / No Codeine allergy
Yes / No Aspirin allergy
Yes / No Latex allergy
Yes / No Other allergies____________________
Yes / No Heart valve replacement, Date:______
Yes / No Heart bypass surgery, Date:__________
Yes / No Heart Attack, Date:_______________
Yes / No Pacemaker, Date:_________________
Yes / No Other heart problems (please list)
____
Yes / No Stroke, Date:____________________
Yes / No Tuberculosis
Yes / No Bleeding tendency (such as abnormal Bleeding from a cut)
Yes / No Diabetes-Type: ________________
Yes / No Cancer, Date:____________
Yes / No High Cholesterol

Yes / No Rheumatic Fever
Yes / No Joint Replacement, Date:_________
Yes / No High blood pressure
Yes / No Asthma
Yes / No Hepatitis, liver disease or jaundice
Yes / No Convulsions, Seizures or Epilepsy
Yes / No AIDS or HIV positive
Yes / No Chemical dependency
Yes / No Glaucoma
Yes / No I.V. Chemotherapy, Date:__________
Yes / No Radiation, Date: ______________
Yes / No Bone Density Medications: (Boniva, Fosamax, etc)
-How long have you been on:__________
Yes / No Tobacco products? (check all that apply)
____Chewing Tobacco
____Smoker/How much?___________
Yes / No Mental Health (such as Dementia, Alzheimer, etc….)
Yes / No Antibiotic prior to Dental work? (Circle one)
Amoxicillin or Clindamycin
*Reason: Heart / Joint / Other:*__________

Yes / No (Women) Are you taking Birth Control?
Yes / No (Women) Do you suspect you may be pregnant?

Have you had any of the following in the past two years?

Yes / No Serious illness____Date:_____________
Yes / No Hospitalization____ Date:_____________
Yes / No Surgery____Date:_____________

Are you under a physician's care at this time?

Yes / No If yes, for what condition(s)?____
Who is your physician, and where is he/she located?____________________________________
____

Yes / No Are you taking any medications? *If yes, please list what they are, and why you take them:
_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance benefits to which I am entitled.

Signature____ Date_________________

Signature____ Date_________________