Welcome

Patient Information:

Patient Name:_____
Last First Middle

Birthdate: _____ Age:_____ Sex:_____ SS #_____

Home Address:_____ City/Sate/Zip:_____

Home Phone #:_____ Work Phone #:_____

Cell Phone #:_____ Employer:_____

Email Address:_____

Check Appropriate Box: □ Minor □ Single □ Married □ Divorced □ Widowed □ Separated

How did you hear about our office? _____

Emergency Contact person:_____ Phone #: _____

Responsible Party Information: (If not patient please complete)

Parent or Spouse Name: (circle one) _____

Address (if different than above) _____

Phone #:_____ Is this person currently a patient? Yes No

Birth Date:_____ SS#: _____

Employer: _____ Work Phone#: _____

Insurance Information: (If other than patient or responsible party please complete below)

Please present office with your insurance card.

Insured's Name:_____ SS#:_____

Birth Date:_____ Phone#:_____

Employer:_____ Work Phone#:_____

Do you have secondary coverage? Please present office with that insurance card as well.

Insured's Name:_____ SS#:_____

Birth Date:_____ Phone#: _____

Employer:_____ Work Phone#: _____

Our dental office will gladly assist you in filing your insurance claim, but we are unable to accept responsibility for collecting your claim if there is a dispute. It is your responsibility to pay for the entire amount not covered by your dental benefit plan. By signing this form, you herby assign all payments for services provided for yourself or dependents to Emergency Dental Care USA.

All accounts 30 days and over are past due and will be subject to an interest rate of 18% per annum. All accounts 90 days past due may be turned over for collection. In the event you or your insurance company fail to pay and it is necessary to employ outside collections efforts, you are responsible for reasonable costs for collection, including but not limited to court costs, attorney fees and collection agency fees.

Responsible party's signature Date

Patient Medical History:

Medical Doctor's Name: _____ Phone#: _____ Date of last visit: _____

How long since your last: Dental visit: _____Cleaning: _____X-rays: _____

1. Are you under medical treatment now?

2. Have you ever been hospitalized for any surgical operation or serious illness?

3. Are you taking any medication(s)? Including non-prescription medications or diet pills? Please list:

4. Do you use alcohol? Or tobacco?

5. Are you wearing contact lens?

6.Are you allergic to or have any reactions to the following:

Local Anesthetics (e.g. Novocaine)	yes	no
Penicillin or other Antibiotics	yes	no
Latex	yes	no
Barbiturates	yes	no
Sedatives	yes	no
Aspirin	yes	no
Metal	yes	no

Other _____

7. Women only:
Are you pregnant or think you may be pregnant?
Are you nursing?
Are you taking birth control medications?

8. Do you have or have you had any of the following? (Explain below)

	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	☐	☐	Hay Fever/allergies	☐	☐	Angina	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Respiratory Problems	☐	☐	Radiation Therapy	☐	☐	Anemia	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Recent Weight Loss / Gain	☐	☐	Cancer	☐	☐
Artificial Heart Valve	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Mitrovalve Prolapse	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Disease	☐	☐	Hepatitis / Jaundice	☐	☐	Asthma	☐	☐
AIDS / HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Diabetes	☐	☐
Thyroid Problems	☐	☐	Stomach Problems / Ulcers	☐	☐	Leukemia	☐	☐

Other _____

Explanation _____

Patient Dental History:

1.Do your gums bleed while brushing or flossing?

2.Are your teeth sensitive to hot or cold foods/liquids?

3.Are your teeth sensitive to sweet or sour foods/liquids?

4.Do you have any sores or lumps in or near your mouth?

5.Have you had any head or neck injuries?

6.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?

7.Do you have frequent headaches?

8.Do you clench or grind your teeth?

9.Have you ever had any difficult extractions?

10.Did you wear braces?

11.Have you had any prolong bleeding following an extraction?

12. Have you ever had instructions on the correct method of brushing your teeth or care of you gums?

13. What is the primary reason for your visit today?

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge.

_____ _____

Signature of Patient or Parent Date Signature of Dentist Date

Are there any changes in your medical / dental history since your last visit? (Initial and date below)