Park Place/Foulk Road Dental

PATIENT INFORMATION AND HEALTH RECORD

Name_____ Date _____
(Last) (First) (MI)
Address_____

Home Phone_____Birth Date_____ Sex_____

Social Security #_____ Personal Physician_____

Business Phone _____Occupation _____

Cell Phone _____ Email Address _____

Employers Name & Address_____

Person Responsible for bill if address different _____

Referred By _____ Closest Relative _____

Spouses Name, Birth Date, Employer _____

Family Members who use this office _____

Dental Insurance_____ Employer_____

(List All) _____ Employer_____

Insured person's name if different _____ SS# _____

Dental Health

Reason for Visit _____ Last Dental Visit _____

Have you ever had any serious problems associated with a previous dental visit?___ If yes, explain _____
_____

How often do you brush your teeth _____ Texture of brush _____ Do your gums feel swollen? _____
Do you grind or clench your teeth _____

Medical Health

Date of last complete physical_____ Are you presently under the care of a physician?_____

If yes, explain_____

Have you been in the hospital or had any serious illness within the past five years?_____ If yes, explain_____
_____

Have you had any radiation treatment for tumors, growths, etc?_____

Do you have any artificial limbs, joints, heart valves, shunt appliances, etc? Explain_____
Are you allergic to: Penicillin _____Codeine_____ Injected Anesthetics_____Other _____

Have you ever taken Bisphosphonates?_____ Are you currently on a blood thinner?_____

Are you taking any medications or drugs for any reasons?_____ If yes, explain_____
_____

Have you ever had or been treated for any of the following, please circle:

Congenital Heart Lesions	Yes	No	Heart Murmur	Yes	No
Heart Disease	Yes	No	Jaundice	Yes	No
Rheumatic Fever	Yes	No	Asthma/ Hay Fever	Yes	No
High Blood Pressure	Yes	No	Sinus Trouble	Yes	No
Ulcers	Yes	No	Lung Disease	Yes	No
Tuberculosis	Yes	No	Hepatitis	Yes	No
Diabetes	Yes	No	Arthritis	Yes	No
Epilepsy	Yes	No	Stroke	Yes	No
Anemia	Yes	No	Glaucoma	Yes	No
Kidney Disease	Yes	No	Venereal Disease	Yes	No
Syphilis	Yes	No	Blood Clots	Yes	No
Hemophilia	Yes	No	Hemodialysis	Yes	No
Herpes	Yes	No	Physical Disability	Yes	No
ARC or Aids	Yes	No	Learning Disability	Yes	No

Do you have any allergies?_____ If yes, to what?_____

Women: Are you pregnant now?_____ Due Date:_____

Have you received blood for any reason?_____ If yes, explain_____

Have you ever been tested for AIDS?_____ Do you have any blood disorder?_____

If yes, explain_____

Do you have prolonged bleeding when cut?_____

Please list any medical condition you may have that is not listed above_____

Do you have any special requests or comments?_____

Patient's Signature_____
(Parent if minor)

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office.

Insurance Authorization of Assignment

I hereby authorize Dr. _____ to furnish information to insurance carriers concerning my treatments and I hereby assign to the dentist(s) all payments for dental services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature_____**Date** _____