DENTAL HEALTH OF FIANNA

Thank you for selecting our team of dental professionals! We will strive to provide you with the best possible dental care. To help us meet all your dental health needs, please fill out this form completely. If you have any questions or need assistance, ask us – we will be happy to help!

Patient Information (CONFIDENTIAL)

Name: _____ Birth Date: _____ Today's date: _____
Email: _____ Social Security#: _____
Home Phone: _____ Cell Phone: _____
Address: _____
City: _____ State: _____ Zip: _____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Patient's or Parent's Employer: _____ Work Phone: _____
Business Address: _____ City: _____ State: _____ Zip: _____
Spouse or Parent's Name: _____ Employer: _____ Work Phone: _____
If patient is a student, name of school or college: _____ City: _____ State: _____
Whom may we thank for referring you? _____
Person to contact in case of an emergency: _____ Phone: _____

Responsible Party

Name of person responsible for this account: _____
Relationship to Patient: _____
Address: _____
Phone: _____ Driver's License #: _____ Birthdate: _____
Employer: _____ Work Phone: _____
Is this person currently a patient at our office? ☐ Yes ☐ No

Insurance Information

Name of Insured: _____ Relationship to Patient: _____
Birthdate: _____ Social Security #: _____ Insurance Company: _____
Name of Employer: _____ Work Phone: _____
Address of Employer: _____ City: _____ State: _____ Zip: _____

Do you have any additional insurance? ☐ Yes ☐ No

Medical History

Physician: _____ Office Phone: _____ Date of Last Exam: _____

	YES	NO
Are you under medical treatment now?	☐	☐
Have you been hospitalized for any surgical operation or serious illness?	☐	☐
Have you ever taken any medication for osteoporosis (Boniva, Fosamax, etc.)?	☐	☐
Are you taking any prescription or nonprescription medications?	☐	☐

If yes, please list all medications: _____

_____

_____

_____

_____

	YES	NO
Do you drink alcohol?	☐	☐
Do you use cocaine?	☐	☐
Do you use other drugs?	☐	☐
Do you wear contact lenses?	☐	☐
Are you pregnant or think you might be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you using any type of birth control?	☐	☐
Do you use tobacco?	☐	☐

If yes, what kind and how frequently?

_____

Are you allergic to or have had a reaction to any of the following?

	Yes	No
Local Anesthetics (lidocaine)	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐

	Yes	No
Aspirin	☐	☐
Latex	☐	☐
Iodine	☐	☐

Other: _____

_____

Do you have or have you had any of the following?

	YES	NO
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
High Cholesterol	☐	☐
Heart Disease/Heart Trouble	☐	☐
Artificial Heart Valve	☐	☐
If yes, when and what type? _____		
_____		
Heart Attack	☐	☐
If yes, date of attack: _____		
Heart Murmur	☐	☐
Cardiac pacemaker	☐	☐
Angina/Chest Pains	☐	☐
Stroke	☐	☐
Rheumatic Fever	☐	☐
Diabetes	☐	☐
If yes, what type? _____		
Swollen Ankles	☐	☐

	YES	NO
Recent Weight Loss	☐	☐
Glaucoma	☐	☐
Frequently Tired	☐	☐
Anemia	☐	☐
Kidney Disease	☐	☐
AIDS or HIV	☐	☐
Sexually Transmitted Disease	☐	☐
Hepatitis	☐	☐
If yes, what type? _____		
Jaundice	☐	☐
Liver Disease	☐	☐
Respiratory Problems	☐	☐
Tuberculosis	☐	☐
Easily Winded	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Hay Fever/Allergies	☐	☐

	YES	NO
Stomach Troubles/Ulcers	☐	☐
Cancer	☐	☐
If yes, what type? _____		
Leukemia	☐	☐
Radiation Therapy	☐	☐
Fainting	☐	☐
Seizures	☐	☐
Epilepsy/Convulsions	☐	☐
Arthritis	☐	☐
Anxiety/Depression	☐	☐
PTSD	☐	☐
Joint Replacement	☐	☐
If yes, what joint and when? _____		
_____		
Thyroid Problems	☐	☐
Other_____		

Authorization and Release

I certify that I have read, understand, and have accurately answered the questions to the best of my knowledge. I understand that providing incorrect or inaccurate information can be dangerous to my health. I authorize Dental Health of Fianna to release any information including the diagnosis and records of any treatment or examination rendered to me or my child to third party payers and/or health practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of myself or my dependents.

X_____ _____

Signature of patient or parent/guardian if patient is a minor **Date**

Doctor's Comments: _____

Doctor's Signature: _____