Welcome

Advanced Dental Center

Age:_____
Today's Date:_____
Patient/Parent SSN#:_____
Spouse SSN#:_____

Patients Name_____Date of Birth_____ **O** Male **O** Female
Last First Initial
If Child: Parents name_____**O** Single **O** Married **O** Separated **O** Divorced **O** Widowed **O** Minor

Street_____City_____State_____Zip_____

Home Phone_____Work Phone_____Cell Phone_____Email:_____

If Student, Name of school/College_____City_____State_____**O** Full Time **O** Part Time

Patient/Parent Employed By_____Present Position_____How Long Held_____

Spouse/Parent Name_____Spouse Employed By_____

Present Position _____How Long Held_____

Purpose Of Call _____Who may we thank for this referral?_____

Emergency Contact?_____Telephone#: _____

RESPONSIBLE PARTY

Who is Responsible for this account_____
For your convenience, we offer the following methods of payments. Please check the option you prefer:
O Cash **O** Personal Check **O** Credit Card **O** Care Credit

INSURANCE INFORMATION

Employee Name:_____Date of Birth:_____ Relationship to patient:_____
Employer Name:_____How long held_____
Name of Insurance Co._____Address:_____
Telephone_____Subscriber Id#_____Group #_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? O YES O NO IF YES COMPLETE THE FOLLOWING:

Employee Name:_____Date of Birth:_____ Relationship to patient:_____
Employer Name:_____How long held_____
Name of Insurance Co._____Address:_____
Telephone_____Subscriber Id#_____Group #_____

PATIENT MEDICAL HISTORY

Physician_____Office Phone#_____Date of last Exam_____

	YES	NO		YES	NO
1. Are you under medical treatment now?.....	O	O	11. Are you wearing contact lenses?	O	O

2. Have you ever been hospitalized for any surgical	O	O
operation or serious illness within the 5 years?.....	O	O
If yes, please explain:_____		
_____		
3. Are you taking any medications including		
non-prescription medicine?.....	O	O
If yes, what medications are you taking?_____		
_____		
_____		
4. Are you taking daily Aspirin or Blood Thinners?...	O	O
5. Have you ever taken Fen-Phen/Redux?	O	O
6. Have you in the last 24hours taken Viagra,	O	O
Revati, Cialis, or Levitra?.....		
7.Have you ever taken Fosmax, Boniva, Actonel,	O	O
or any other medication for Osteoporosis?.....		
8.Do you use tobacco	O	O
9. Do you use controlled substances?	O	O
10. Do you consume alcohol?	O	O
If yes how many per day?_____		

12. Are you allergic to or have you had any		
reaction to the following?	O	O
Local Anesthetics (Novocaine)	O	O
Penicillin or any other antibiotics	O	O
Sulfa Drugs	O	O
Barbiturates	O	O
Sedatives	O	O
Iodine	O	O
Aspirin	O	O
Any metals (e.g. Nickel, Mercury, etc.)	O	O
Latex Rubber	O	O
Other_____		
13. Do you have a persistent cough or throat clearing not associated		
with a known illness (lasting more than 3 weeks)?	O	O
Women Only:		
A) Are you pregnant?	O	O
If yes, how far along_____		
B) Are you nursing?	O	O
C) Are you taking oral contraceptives?	O	O

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

	YES	NO		YES	NO		YES	NO
High Blood Pressure	O	O	Stroke	O	O	Tuberculosis	O	O
Low Blood Pressure	O	O	Hay Fever/Allergies	O	O	Recent Weight loss	O	O
Heart Attack	O	O	Rheumatic Fever	O	O	Liver Disease	O	O
Heart Disease	O	O	Frequently Tired	O	O	Easily Winded	O	O
Mitral Valve Prolapse	O	O	Anemia	O	O	Respiratory Problems	O	O
Cardiac Peacemaker	O	O	Asthma	O	O	Cancer	O	O
Artificial Heart Valves	O	O	Swollen Ankles	O	O	Radiation Therapy/Chemotherapy	O	O
Stents	O	O	Arthritis	O	O	Problems with mental health	O	O
Joint Replacements or Implants	O	O	Fainting/Seizures	O	O	Thyroid Problem	O	O
Excessive Bleeding	O	O	Epilepsy/Convulsions	O	O	Kidney Disease O	O	
Angina/Chest Pain	O	O	Osteoporosis	O	O	Diabetes	O	O
Auto Immune Disease	O	O	Aids or HIV Infection	O	O	Hepatitis	O	O
Sexually Transmitted Disease	O	O	Other:					

PATIENT DENTAL HISTORY

Name of previous Dentist and Location:_____Date of Last Exam__ _____

	YES	NO
1.Have you ever needed to take antibiotic premeditation before		
dental visits?	O	O
2. Do your gums bleed while brushing or flossing?	O	O
3. Are your teeth sensitive?	O	O
4. Do you feel pain to any of your teeth?	O	O
5. Do you have any sores or lumps in or near your mouth?	O	O
6. Have you had any head, neck, or jaw injuries?	O	O
7. Have you ever had difficult extractions in the past	O	O
8. Have you had any orthodontic treatment?	O	O
9. Do you often feel TIRED, fatigued or sleepy during daytime?	O	O
10. Do you experience dry mouth?	O	O

	YES	NO
11. Has anyone OBSERVED you stop breathing during your sleep?	O	O
12. Have you ever been diagnosed with Sleep Apnea?	O	O
13. Have you ever experienced any of the following problems with your jaw?	O	O
Clicking	O	O
Pain(joint,ear, side of face)	O	O
Difficulty in opening or closing	O	O
Difficulty in chewing	O	O
14. Do you have frequent headaches?	O	O
15. Do you clench or grind your teeth?	O	O
16. Do you wear any removable appliance?	O	O
If yes date of placement?_____		

AUTHORIZATION AND RELEASE

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT unless prior arrangements have been approved. This office accepts insurance,I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance otherwise payable to me. I understand that I am responsible for all cost of dental treatment. I hereby authorize release of any information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence ant it is my responsibility to inform the office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I acknowledge receipt of the offices privacy policy. I give my permission to release any medical information if necessary.

X_____ _____

Signature of patient(or parent/guardian if minor) Date