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

Birth date_____ Cell Phone_____ Home Phone_____

Address_____City_____ Zip_____

Email_____ Sex: M F Age_____

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

In Case of emergency, contact_____Phone_____

INSURANCE INFORMATION:

Any Changes to Dental Insurance since last visit? ***YES / NO*** If yes, please complete information below…….

Name of Insured:_____ Birth date of policy holder_____

Dental Insurance Company:_____

Subscriber ID:_____

Group #:_____

Please list all family members included in plan:_____

_____ _____

_____ _____

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
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 Bone Density Medications: (Boniva, Fosamax, etc)
-How long have you been on:_____

Yes / No Tobacco products? (check all that apply)
_____Chewing Tobacco
_____Smoker
Yes / No Mental Health (such as Dementia, Alzheimer's, etc….)
Yes / No Premedicate/_____

Yes / No (Women) Are you taking oral contraceptives?
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_____