Freeport Family Dental

PATIENT INFORMATION Date _____

Name _____ Birth Date_____ Social Security _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email Address _____

□ Minor □ Single □ Married □ Divorced □ Widowed □ Male □ Female

Employer _____ Phone _____

Address _____ City _____ State _____ Zip _____

Emergency Contact _____ Phone _____

RESPONSIBLE PARTY (Must be present and sign if other than parent (if minor), or spouse)

Parent, Spouse or other person responsible for this account: Relationship to patient _____

Name _____ Birth Date_____ Social Security _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email Address _____

Employer _____ Phone _____

DENTAL INSURANCE

Name of Insured _____ Relationship to Insured _____ Birth Date:_____

Social Security # _____

If group insurance, name of Employer _____ Phone _____

Please present your insurance card or complete insurance information:

Insurance Company _____ Group # _____ Member ID _____

Insurance Company claim submission address _____

Do you have secondary insurance? □ Yes (complete the following) □ No

Name of Insured_____ Relationship to Insured _____

If group insurance, name of Employer _____ Phone _____

Please present your insurance card or complete insurance information:

Insurance Company _____ Group # _____ Member ID _____

Insurance Company claim submission address _____

Were you referred to our office? If so, whom may we thank? _____

over ➔

PATIENT DENTAL HISTORY

Name and location of previous dentist _____

Date of last exam _____

Do your gums bleed while brushing or flossing? □Yes □No
Are your teeth sensitive to hot or cold liquids/foods? □Yes □No
Are your teeth sensitive to sweet or sour liquids/foods? □Yes □No
Do you feel pain to any of your teeth? □Yes □No
Do you have any lumps or sores in or near your mouth? □Yes □No
Have you had any head, neck, or jaw injuries? □Yes □No

Have you ever experienced any of the following problems in your jaw?
Clicking □Yes □No
Pain (joint, ear, side of face) □Yes □No
Difficulty in opening and closing □Yes □No
Difficulty in chewing □Yes □No

Do you have frequent headaches? □Yes □No
Do you clench or grind your teeth? □Yes □No
Do you bite your lips or checks frequently □Yes □No
Have you ever had any difficult extractions in the past?
Have you ever had any prolonged bleeding following extractions? □Yes □No
Have you had any orthodontic treatment? □Yes □No
Do you wear dentures or partials? □Yes □No
If yes, date of placement _____
Have you ever received oral hygiene instructions regarding the care of your teeth and gums? □Yes □No
Do you like your smile? □Yes □No

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information and the following medical information to the best of my knowledge and have answered all questions accurately. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. 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 my behalf or my dependants.

_____
Signature of patient (or parent or legal guardian, if minor)

_____
Signature of responsible party, if other than patient

PATIENT MEDICAL HISTORY Patient Name _____ Date _____

Physician _____ Phone _____ Date of last exam _____

Are you under medical treatment now? □Yes □No
Have you ever been hospitalized for any surgical operation or serious illness in the last 5 years? □Yes □No

If yes, please explain _____

Are you taking any medication(s) including non-prescription medicine? □Yes □No
If yes, what medication(s) are you taking?(Attach list if necessary)

Are you allergic to or have had any reactions to the following:

Local anesthetics (Novocaine)	□Yes □No
Penicillin or any other antibiotic	□Yes □No
Sulfa drugs	□Yes □No
Barbiturates	□Yes □No
Sedatives	□Yes □No
Iodine	□Yes □No
Aspirin	□Yes □No
Any metals (Nickel, Mercury, etc.)	□Yes □No
Latex rubber	□Yes □No
Other (list)_____	

Are you taking any herbal treatments? □Yes □No

Do you use tobacco? □Yes □No
Do you use controlled substances? □Yes □No
Are you wearing contact lenses? □Yes □No

Women only:
Are you pregnant or think you might be pregnant? □Yes □No
Are you nursing? □Yes □No
Are you taking oral contraceptives? □Yes □No

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

High blood pressure	□Yes □No	Cardiac pacemaker	□Yes □No	Chest pains	□Yes □No
Heart attack	□Yes □No	Heart murmur	□Yes □No	Easily winded	□Yes □No
Rheumatic fever	□Yes □No	Angina	□Yes □No	Stroke	□Yes □No
Swollen ankles	□Yes □No	Frequently tired	□Yes □No	Hay Fever/Allergies	□Yes □No
Fainting/seizures	□Yes □No	Emphysema	□Yes □No	Tuberculosis	□Yes □No
Asthma	□Yes □No	Cancer	□Yes □No	Radiation Therapy	□Yes □No
Low blood pressure	□Yes □No	Type_____		Glaucoma	□Yes □No
Epilepsy/convulsions	□Yes □No	Type_____		Recent weight loss	□Yes □No
Leukemia	□Yes □No			Liver disease	□Yes □No
Diabetes	□Yes □No	Arthritis	□Yes □No	Heart trouble	□Yes □No
Kidney disease	□Yes □No	Joint replacement/implant	□Yes □No	Respiratory problems	□Yes □No
AIDS or HIV infections	□Yes □No	Hepatitis/Jaundice	□Yes □No	Mitral valve prolapsed	□Yes □No
Thyroid problem	□Yes □No	Sexually transmitted disease	□Yes □No	Other _____	
Heart disease	□Yes □No	Stomach troubles/ulcers	□Yes □No		

BISPHOSPHONATES – Please indicate if you are on any of the following:

Oral forms used to treat Osteoporosis:

Generic	Brand
Etidronate	Didronel
Risedronate	Actonel
Tiludronate	Skelid
Alendronate	Fosamax

IV forms used to treat Multiple Myeloma, Metastatic Breast Cancer, and Metastatic Prostate Cancer:

Generic	Brand
Pamidronate	Aredia
Zoledsonate	Zometa

Date of last update:
