ADVANCED CARE DENTAL CENTER

Cosmetic, Family, & Implant Dentistry

About You

Today's Date: ____________

Patient Name: ____________
Last First MI Mr. Mrs. Ms. Dr.

I like to be called: ____________ ☐ Male ☐ Female

Birthdate: ___/___/___ Age: ____ SS#: ____________

Whom may we thank for referring?

Referred by: ____________

Payment or Co-payment is due in full at the time treatment unless prior arrangements have been approved.

Method of Payment:

- ☐ Cash
- ☐ Visa or Mastercard
- ☐ Dental insurance & co-payment
- ☐ Other health care financial support
- ☐ Medical coupons

Patient or Responsible Party

Name: ____________
Last First MI Mr. Mrs. Ms. Dr.

Home Address: ____________
ApVCondo .

____
City State Zip

How long at this address: ________ Relation to patient: ________

Home #: ____________

Cell #: ____________

Work #: ____________ Ext. ________ SS#: ________

Email : ____________

Birthdate: ___/___/___ DL# ____________

Employer /Self-Employment: ____________

Employer's Address: ____________

No. Years of employment: ________ Occupation: ________

Dental Insurance

PRIMARY DENTAL INSURANCE

Insurance Co. Name: ____________

Insurance Co. Address: ____________

Insurance Co. Phone #: ____________

Group # (Plan, Local or Policy #): ____________

Insured's Name: ____________ Relation: ________

Insured's Birthdate: ___/___/___ Insured's SS#: ________

Insured's Employer: ____________

Insured's Address: ____________

SECONDARY DENTAL INSURANCE

Insurance Co. Name: ____________

Insurance Co. Address: ____________

Insurance Co. Phone #: ____________

Group # (Plan, Local or Policy #): ____________

Insured's Birthdate: ___/___/___ Insured's SS#: ________

Insured's Employer: ____________

Insured's Address: ____________

Other Family Members

NAME	AGE
Spouse	
Children	

Today's visit is for:

____

____

____

Medicine taken: ____________

In the event of an emergency, is there someone that we should contact?

His/Her Name: ____________ Relation: ________

Work #: ____________ Home #: ________

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: ____________________

Phone #: ____________ Date of last visit: ________

Your current physical health is: ☐ Good ☐ Fair ☐ poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: ____________________

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Are you taking any prescription/over-the-counter drugs? ☐ Yes ☐ No

Please list each one: ____________________

For Women: *Are you taking birth control pills?* ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No *Week #:* ____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following
Diseases or medical problems

Y N

Y N	Anemia / Radiation Treatment	Y N	Heart Surgery / Pacemaker
Y N	Artificial Bones / Joints	Y N	Hemophilia/Abnormal Bleeding
Y N	Artificial Valves	Y N	Hepatitis
Y N	Asthma / Arthritis	Y N	High / Low Blood Pressure
Y N	Blood Transfusion	Y N	HIV+ / AIDS
Y N	Cancer / Chemotherapy	Y N	Hospitalized for any reason
Y N	Congenital Heart Defect	Y N	Kidney Problems
Y N	Diabetes / Tuberculosis (TB)	Y N	Mitral Valve Prolapse
Y N	Difficulty Breathing	Y N	Psychiatric Problems
Y N	Drug / Alcohol Abuse	Y N	Rheumatic / Scarlet Fever
Y N	Emphysema / Glaucoma	Y N	Severe / Frequent Headaches
Y N	Epilepsy/Seizures/Fainting Spells	Y N	Sinus Problems
Y N	Fever Blisters / Herpes	Y N	Ulcers / Colitis
Y N	Heart Attack / Stroke	Y N	Venereal Disease
Y N	Heart Murmur		

Please list any serious medical condition(s) that you have ever had:

____

____

Are you allergic to any of the following?

Y N		Y N		Y N	
Y N	Aspirin	Y N	Erythromycin	Y N	Tetracycline
Y N	Codeine	Y N	Latex, Rubber	Y N	Oher
'Y N	Local Anesthetics	Y N	Penicillin		

Please list any other drugs that you are allergic to: ____________________

____

Dental History

Previous/present dentist Name: ____________________

Phone #: ____________ Location: ____________

Last Cleaning Date: ____________________

Do you now or have you ever experienced pain! discomfort in your jaw joint (TMJITMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

How many times a week do you brush?______ Floss?________

Have you lost any teeth? ☐ Yes ☐ No If yes, why? ________

Have you ever had any of the following?	**Yes**	**No**
Do your gums bleed while brushing or flossing?	☐	☐
Tooth sensitivity to heat or cold?	☐	☐
Tooth sensitivity to sweet or sour liquids/foods?	☐	☐
Pain in any of your teeth	☐	☐
Sores or lumps in or near your mouth	☐	☐
Head, neck or jaw injuries?	☐	☐
Any clicking, pain, or difficulty opening, closing or chewing in your jaw?	☐	☐
Frequent headaches?	☐	☐
Clenching or grinding your teeth?	☐	☐
Frequent biting of cheeks or lips?	☐	☐
experienced a difficult extraction or prolonged bleeding following?	☐	☐
orthodontic treatment	☐	☐

Additional Comments:

____

____

____

I understand that the 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 and it is my responsibility to inform this office of any changes in my medical status.

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.

Signature: ____________________ Date: ________

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Reviewed with ____________ Date: ________

Doctor's Comments: ____________________

____

MEDICAL HISTORY UPDATE

I have read my medical history dated ______ and confirmed that it states past and present medical conditions.

____________________ Signature

________ Date

I have read my medical history dated _______ and confirmed that it states past and present medical conditions.

____ ____________
Signature Date

I have read my medical history dated _______ and confirmed that it states past and present medical conditions.

____ ____________
Signature Date