FAMILY DENTISTRY
on park
WWW.FAMILYDENTISTRYONPARK.COM

WELCOME BACK – PLEASE UPDATE!

Today's Date: _____

ABOUT YOU

First Name: _____ *Middle Initial:* _____ *Last Name:* _____

Address: _____
Street City State Zip Code

Email: _____ *Social Security Number:* _____

Birth date: _____ *Home Phone:* _____ *Mobile Phone:* _____

EMERGENCY CONTACT

Name: _____ *Relation to you:* _____ *Cell Phone:* _____

INSURANCE INFORMATION (if changed)

Primary Insurance Company: _____ *Policy Holder Name:* _____

Policy Holder's DOB: _____ *Policy Holder's ID #:* _____ *Group #:* _____

Secondary Ins Company: _____ *Policy Holder Name:* _____

Policy Holder's DOB: _____ *Policy Holder's ID #:* _____ *Group #:* _____

MEDICAL HISTORY

Physician name: _____ *Physician Phone:* _____

Pharmacy Name: _____ *Pharmacy Phone:*_____

Have you ever had a blood transfusion/serious illnesses/ operations/ artificial joint replacement? ❑ Yes ❑ No

If yes please explain: _____

Do you need antibiotics prior to dental work? ❑ Yes ❑ No *If yes please explain:* _____

Are you currently taking any Medications? ❑ Yes ❑ No *If yes please list:* _____

_____

_____

ALLERGIES

❑ *None* ❑ *Seasonal* ❑ *Latex* ❑ *Food:* _____ ❑ *Medications:*_____ ❑ *Other*_____

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Full Name: _____

PLEASE CHECK IF YOU HAVE/HAD: ❑ ***None***

❑ *Hay fever, sinusitis*	❑ *Cough, persistent or bloody*	❑ *Anemia*
❑ *Diabetes*	❑ *Chemotherapy*	❑ *Mitral Valve Prolapse*
❑ *Arthritis, Rheumatism*	❑ *Emphysema*	❑ *Circulatory Problems*
❑ *Artificial Heart Valves*	❑ *Epilepsy*	❑ *Cortisone Treatments*
❑ *Asthma*	❑ *Asthma: Req'd Hospitalization*	❑ *Glaucoma*
❑ *Herpes*	❑ *Heart Problems*	❑ *Fainting*
❑ *Asthma: Used Steroid*	❑ *Headaches*	❑ *Heart Murmur*
❑ *Jaundice*	❑ *Cancer (Type _____)*	❑ *Hepatitis (Type _____)*
❑ *Low Blood Pressure*	❑ *High Blood Pressure*	❑ *Osteopenia*
❑ *Pacemaker*	❑ *Radiation Treatments*	❑ *Rheumatic Fever*
❑ *Respiratory Disease*	❑ *Scarlet Fever*	❑ *Shortness of Breath*
❑ *Kidney Disease*	❑ *Chemical Dependency*	❑ *Blood Disease, Clotting Disorders*
❑ *Stroke*	❑ *Swelling of feet/Ankles*	❑ *Thyroid Problems*
❑ *Tonsillitis*	❑ *Tumor or Growth*	❑ *Ulcer*
❑ *Venereal Disease*	❑ *Unexplained Weight Loss*	❑ *Contact lenses*
❑ *HIV/AIDS*	❑ *Disorders*	❑ *Immune Deficiency*
❑ *Bleeding abnormally with operation/surgery*		❑ *Pregnant or Nursing*

❑ *Other,* _____

❑ *Do you consume alcoholic beverages? How often?* _____

AUTHORIZATION AND RELEASE

APPOINTMENT POLICY: PLEASE NOTIFY THIS OFFICE 24 HOURS PRIOR TO AN APPOINTMENT IF YOU MUST CANCEL. THIS OFFICE RESERVES THE RIGHT TO CHARGE A $50 PER HALF HOUR CANCELLATION FEE.

Patient's Signature: _____ *Date:* _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing the incorrect information can be dangerous to my health. I hereby authorize this office to administer and perform the necessary procedures, such as x-rays, anesthetics and dental treatment deemed necessary or advisable with the diagnosis of my dental condition. I understand there are certain risks inherent in dental treatment; such as but not limited to: pulpal sensitivity or damage, tissue swelling or brushing, soreness of jaws, paresthesia and other procedure specific risks.

I understand that I am responsible for payment of services by this office, and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize this office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submission, whether manual or electronic.

Patient's Signature: _____ *Date:* _____

Our office is HIPAA compliant and is committed to exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.