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: ______________

Other Family Members

NAME	AGE
Spouse	
Children	

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: ______________________________

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

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

____

____

Are you allergic to any of the following?

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

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:

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____

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