WELCOME to IDEAL DENTISTRY!

To assist us in serving you, please complete the following confidential forms.

PATIENT INFORMATION

Last Name First Name M.I.

Birthdate Soc. Sec.# Sex M F

Street Address City

State Zip Employer

Occupation Marital Status

Email Home Phone

Cell Phone Work Phone

NOTIFY IN CASE OF EMERGENCY Phone

PRIMARY DENTAL INSURANCE

Responsible Party for Account

Last Name First Name M.I.

Relation to Patient Birthdate Soc. Sec. #

Address (If different from Patient) Phone

City State Zip

Responsible Party's Employer Occupation

Business Address

Business Phone Insurance Company

Contract # Group # Subscriber #

Name of other dependents on this plan

SECONDARY DENTAL INSURANCE

Subscriber's Name Relation to Patient Birthdate

Address (If different from Patient)

City State Zip

Subscriber's Employer Business Phone

Insurance Company Soc. Sec. #

Contract # Group # Subscriber #

Name of other dependents on this plan

HOW DID YOU FIND OUT ABOUT OUR DENTAL PRACTICE

Referral (By Whom) Daily News Sun Google Ad

Google Search Yelp Yahoo Bing Facebook Pinterest Other

AUTHORIZATION

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge.

I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I authorize my insurance company to pay Ideal Dentistry all insurance benefits otherwise payable to me for services rendered.

I authorize the use of this signature on all insurance submissions. I authorize Ideal Dentistry to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. **Payment is due in full at time of treatment.**

Signature_____**Date**_____

MEDICAL HISTORY

1. Are you having pain or discomfort at this time? Yes No
2. Do you feel nervous about having dental treatment? Yes No
3. Have you ever had a bad experience in the dental office? Yes No
4. Have you been a patient in the hospital during the past two years? Yes No
5. Have you been under the care of a medical doctor during the past two years? Yes No

Physician's Name _____ Phone Number _____

6. Have you taken any medications or drugs during the past two years? Yes No
7. Are you currently taking any medications, drugs, or pills? Yes No

If yes, please list: _____

_____

_____

8. Have you ever taken Fen-Phen? Yes No
9. Are you **allergic** to or have you ever had any **adverse reactions** to the following?

Aspirin	Yes	No	Tetracycline	Yes	No	Nembutal/Seconal	Yes	No
Darvon	Yes	No	Percodan	Yes	No	Penicillin	Yes	No
Codeine	Yes	No	Valium	Yes	No	Other Antibiotics	Yes	No
Demerol	Yes	No	Scopolamine	Yes	No	Novacaine	Yes	No
Nitrous Oxide	Yes	No	Local Anesthetic	Yes	No	Xylocaine	Yes	No
Erythromycin	Yes	No	Sleeping Pills	Yes	No	Latex	Yes	No

10. Are you aware of being allergic to or have you ever had any adverse reactions to any medication not listed?

Yes No If yes, Please list: _____

11. Indicate which of the following you have had or presently have. Circle "yes" or "no" to each item.

									DATE
Heart Failure	Yes	No	**Emphysema**	Yes	No	**Hepatitis A**	Yes	No	
Heart Disease or Attack	Yes	No	**Chronic Cough**	Yes	No	**Hepatitis B**	Yes	No	
Angina Pectoris	Yes	No	**Tuberculosis (TB)**	Yes	No	**Hepatitis C**	Yes	No	
High Blood Pressure	Yes	No	**Asthma**	Yes	No	**Liver Disease**	Yes	No	
Heart Murmur	Yes	No	**Sinus Trouble**	Yes	No	**Yellow Jaundice**	Yes	No	
Mitral Valve Prolapse	Yes	No	**Diabetes**	Yes	No	**Blood Transfusion**	Yes	No	
Rheumatic Fever	Yes	No	**Thyroid Disease**	Yes	No	**Drug Addiction**	Yes	No	
Congenital Heart Lesions	Yes	No	**Hemophilia**	Yes	No	**X-ray**	Yes	No	
Scarlet Fever	Yes	No	**Chemotherapy**	Yes	No	**Venereal Disease**	Yes	No	
Artificial Heart Valve	Yes	No	**Cancer**	Yes	No	**Cold Sores**	Yes	No	
Heart Pacemaker	Yes	No	**Arthritis**	Yes	No	**Epilepsy**	Yes	No	
Heart Surgery	Yes	No	**Cortisone Medicine**	Yes	No	**Seizures**	Yes	No	
Artificial Joints	Yes	No	**Glaucoma**	Yes	No	**Fainting**	Yes	No	
Anemia	Yes	No	**Pain in Jaw Joints**	Yes	No	**Dizzy Spells**	Yes	No	
Stroke	Yes	No	**A.I.D.S.**	Yes	No	**Sickle Cell Disease**	Yes	No	
Kidney Trouble	Yes	No	**ARC-HIV positive**	Yes	No	**Bruise Easily**	Yes	No	
Ulcers	Yes	No	**Smoker**	Yes	No	**Chew Tobacco**	Yes	No	

12. Are you on a special diet? Yes No
13. Has your medical doctor ever said you have cancer or tumor? Yes No
14. Do you have any disease, condition, or problem not listed? Yes No
15. Do you pre-medicate with antibiotics before dental treatment? Yes No

WOMEN ONLY: Are you pregnant? **Yes** **No** If yes, what month? _____

Are you taking birth control pills? Yes No