DREW FAMILY DENTISTRY

GETTING TO KNOW YOU

PATIENT NAME	PREFERRED NAME	BIRTH DATE / /
IF MINOR, GUARDIAN'S NAME	PREFERRED CONTACT PHONE NUMBER CIRCLE ONE (MOBILE / HOME / WORK)	EMAIL
MAILING ADDRESS	CITY, STATE, ZIP	SOCIAL SECURITY NUMBER
EMPLOYER	OCCUPATION	MARITAL STATUS
EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE NUMBER (MOBILE / HOME / WORK)	PATIENT GENDER ☐ Male ☐ Female

DENTAL INSURANCE HOLDER INFORMATION

☐ NOT COVERED BY DENTAL INSURANCE

PRIMARY INSURANCE COMPANY:	GROUP:	SUBSCRIBER:
SECONDARY INSURANCE COMPANY:	GROUP:	SUBSCRIBER:

NAME	BIRTH DATE / /	SOCIAL SECURITY NUMBER
HOME ADDRESS	CITY, STATE, ZIP	DAYTIME PHONE
RELATIONSHIP TO PATIENT	RESPONSIBLE PARTY EMPLOYER	RESPONSIBLE PARTY WORK PHONE

How did you hear about our office?

☐ Referred by a friend ☐ Relative ☐ Insurance Plan ☐ Google Search ☐ Facebook ☐ Direct Mailing ☐ Sign by building

☐ Other: ____________________ **If you were referred, whom may we thank for referring you?** ____________________

CONSENT

I will answer all health questions to the best of my knowledge ____________ (initial)

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patient and whatever procedures that the judgment of the doctor may decide in order to carry out those procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

TERMS & CONDITIONS

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial agreements must be made in advance. All emergency dental service, or any dental service performed without prior financial arrangements must be paid for at the time the services are rendered. I understand that dental services furnished to me are charged directly to me are charged directly to me and that I am personally responsible for payment. If i carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of insurance: I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this Office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my social security number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to assignee, to telephone me at my home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

Signature: ______________________________ Date: ____________________

DREW FAMILY DENTISTRY

PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Do you have any specific areas of concern that you would like us to address? ______________________________

____

Are you happy with your smile? ☐YES ☐NO

Are there any specific things you have had done in the past that made your dental visit more comfortable? ______________________________

____

Please mark any of the services offered here that you would like more information on:

☐Invisalign/Orthodontics ☐Whitening ☐TMJ/Jaw Pain ☐Dental Implants ☐Veneers/Cosmetic Dentistry ☐Sleep Apnea CPAP Alternatives
☐Athletic Mouthguards ☐Other: ______________________________

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following:
(Please check all that apply)

☐Abnormal bleeding after extractions, surgery or trauma
☐AIDS or HIV Positive
☐Alcoholism
☐Anemia or blood disorders
☐Artificial joint or valve, when? ______________________________
☐Asthma
☐Auto-immune disorders
☐Cancer or tumor
☐Diabetes (Type 1 / Type 2)
☐Epilepsy, seizures, or fainting spells
☐Hay fever or sinus trouble
☐Heart attack, when? ______________________________
☐Heart condition, specify ______________________________
☐Hepatitis or other liver disease
☐ Herpes or cold sores
☐High blood pressure
☐Kidney disease or problems
☐Migraine headaches or frequent headaches
☐Pacemaker
☐Stroke, when? ______________________________
☐Tuberculosis or other lung problems

Women:
☐May be pregnant -- Expected delivery date? ______________________________
☐ Taking hormones or contraceptives

Are you allergic to, or have you reacted adversely to any of the following?

☐Codeine or other narcotics
☐Latex materials
☐Local anesthetics ("Novocaine")
☐Penicillin or other antibiotics
☐Sulfa drugs
☐Other: ______________________________

Do you smoke or use chewing tobacco? ☐ YES ☐NO

Have you ever taken antibiotics for dental treatment? ☐YES ☐NO

If yes, then please explain why: ______________________________

____

Name of your physician: ______________________________

Please list the current medications you are taking:

____
____
____
____
____

Do you have any disease, condition or problem not listed above? Please describe:	Please add anything you would like us to know about:

OVER →