Welcome to Friendly Dental

Patient Information (Confidential)

Name____Birthdate________________ SSN______________________

Address_______________________________________City____________________State________ Zip__________

Home Phone_________________________ Cell Phone________________________

Minor ______ Single______Married_______Divorced_______Widowed_______Separated_______

Person to Contact in Case of Emergency____Phone______________

Whom May We Thank for Referring you? ____

Responsible Party

Name of Person Responsible for this Account_______________________________Relationship to Patient__________

Address____ Home Phone_________________

Driver's License# __________________________Birthdate____________________SSN_______________________

Employer____________________________Work Phone_____________Financial Institution____________________

Is this Person currently a Patient in our Office? Yes____ No____

For your convenience, we offer the following methods of payment. Please check the option you prefer.

Cash___ Check___ Credit Card___ (Visa, MC or Discover, Am. Express) Capital One Payment Plan___

Insurance Information

Name of Insured____Relationship to Patient_________________

Birthdate of Insured ________________________Employer____

Insurance Company_______________________________ID #____________________Group #__________________

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? Yes________ No________

If yes, please provide
information:____

PLEASE NOTE: I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Patient Medical History

Medical Physician ________________________________ Date of LastExam______________________

Are you under medical treatment now? Yes No
Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? Yes No
If yes, please explain ___________________________
Are you taking any medications including non-prescription medicine? Yes No
If yes, please list medications_________________
____
Are you taking or have you ever Taken Fosamax? Yes No
How long? ________________
Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) Yes No

Have you ever taken Fen-Phen/Redux? Yes No
Do you use tobacco? Yes No
Do you use controlled substances? Yes No
Are you wearing contact lenses? Yes No

WOMEN ONLY:
Are you pregnant or think you may be pregnant? Yes No
Are you nursing? Yes No
Are you taking oral contraceptives? Yes No

Are you allergic to or have you had any reactions to the following? Please indicate with a ✓

Local Anesthetics (Novocain) _____ Penicillin _____ Sulfa Drugs _____ Barbiturates _____ Iodine______
Sedatives _____ Aspirin ______ Any Metals (nickel, mercury, etc) _____ Latex rubber ______

Do you have or have you had any of the following? Please indicate with a ____

______ High blood pressure ______ Heart Attack ______ Chest Pains
______ Heart Disease ______ Cardiac Pacemaker ______ Easily Winded
______ Rheumatic Fever ______ Heart Murmur ______ Stroke
______ Swollen Ankles ______ Angina ______ Hay fever/Allergies
______ Fainting/Seizures ______ Frequently tired ______ Tuberculosis
______ Asthma ______ Anemia ______ Radiation Therapy
______ Low Blood Pressure ______ Emphysema ______ Glaucoma
______ Epilepsy/Convulsions ______ Cancer ______ Recent Weight Loss
______ Leukemia ______ Arthritis ______ Liver Disease
______ Diabetes ______ Joint replacement or implant ______ Heart Trouble
______ Kidney Disease ______ Hepatitis/Jaundice ______ Respiratory Problems
______ AIDS or HIV infection ______ Sexually Transmitted Disease ______ Mitral Valve Prolapse
______ Thyroid problem ______ Stomach Troubles/Ulcers

Are there any other health concerns or problems that we should be aware of? ________________________
____

Patient Dental History

Name of Previous Dentist_____________________________________ Date of Last Exam____________________

Do you have or have you had any of the following – please indicate with a ✓

___ Bleeding gums
___ Sores or lumps in your mouth
___ Head, neck or jaw injury
___ Frequent headaches
___ Tooth pain or pressure
___ Clench or grind teeth
___ Prolonged bleeding following extractions
___ Teeth sensitive to hot, cold or sweets
___ Difficult extractions in the past
___ Have you ever had oral hygiene instruction?
___ Orthodontic treatment
___ Dentures or partials

Have you experienced any of the following:
___ Clicking ___ Pain (joint, ear, side of face) ___ Difficulty in opening or closing ___ Difficulty in chewing ___ Dry mouth

Do you have any other dental problems or concerns we should be aware of?
____

Certification and Financial Agreement

To the best of my knowledge, the information provided on this form is complete and correct. I understand that it is my responsibility to inform my doctor if there is a change in my health. I acknowledge that payment is due at time of
Treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of minor/child. I accept full financial responsibility for all charges for services or items provided to me or the patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

____ ________________________
Signature of parent, guardian or personal representative Date