Elkhart Dental Center, P.C

Patient Information

Patient Name: ____ Date of birth: ______________
First MI Last month day year

Social security # ____

☐Male ☐Female ☐married ☐single ☐divorced

Address:__________________________________ City______________ State_______ Zip___________

Home phone# ________________________________ Cell phone #________________________________

Employer ___________________________________ Occupation ______________________________
Work phone#

Spouse or Responsible Party Information

☐ Parent ☐ spouse ☐ Self (If self, go to Insurance section)

Responsible party name: ____ Date of birth ____________

Street address _____________________________________ City ___________ State______ Zip__________
Social Security #: __________________________________

Employer ______________________________________ Occupation ______________________________
Work phone ______________________________

Insurance Information

Primary insurance company name _____________________________ Employer name__________________

Name of Insured ____ ID# __________________________

Insured's Birth date _______________

Secondary insurance company name ___________________________ Employer name__________________

Name of Insured ____ ID# __________________________

Insured's Birth date _______________

Person to contact if unable to reach you

Name ____ Relationship to you ___________________

Street address ______________________________ City______________ State ________ Zip____________
Phone #

Is anyone in your immediate family currently a patient with us? If yes, who

Name ____ Reltionship_____________________

Health Information

Date of Last Dental Visit:_______________ Reason for this visit: _______________________________________

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Hepatitis ☐A or ☐B or Hepatitis ☐C
- ☐ HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems

OTHER:
- ☐ _________________
- ☐ _________________

Artificial Joints ☐ yes (if yes, please answer below) ☐ no

☐ Total joint replacement OR ☐ Pins, Plates or screws

☐ You've had previous infections in your artificial joint.

Date of joint surgery _______________________

Orthopaedic Surgeon _______________________ Phone#________________________________

Heart disease

☐Artificial heart valves

☐A history of infective endocarditis

☐Certain specific serious congenital (present from birth) heart conditions______________________________________

☐Any repaired congenital heart defect with prosthetic material or device

☐a cardiac transplant that develops a problem in a heart valve

Are you **pregnant**? ☐ Yes ☐ No If yes, what month? ___________ • Are you nursing? ☐ Yes ☐ No

Are you taking any type of birth control? ☐ Yes ☐ No

• **Are you taking any medications**? ☐ Yes ☐ No

If yes please list: ____

•Are you **allergic** to anything? ☐ Yes ☐ No

If yes please list: ____

• Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain: ____

• Are you now under the care of a physician? ☐ Yes ☐ No

If yes, please explain: ____

• Name of Physician: ____ Phone: ____________________________

• Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain: ____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

SignatureX____ **Date:**_________________

Person to contact for emergency (not living with you)

Name____ phone # ____________________________

Address____ State _________ Zip code_________________

Consent for Services

The undersigned hereby authorizes doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform and all forms of treatment, medication and therapy, which may be indicated in connection with **(Name of patient)** ____

And further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk.

X____ Date: ________________

Signature of patient,

X____ Date: ________________ Relationship to Patient:______________________

Signature of guarantor of payment/responsible party