Central Park Dental

Patient Information

Patient Name _____ M F Date of Birth _____

Married: Yes or No SSN: _____

Patient Address: _____ City, State, Zip_____

Home Tel: ( ) _____-_____ Work: ( ) _____-_____ Cell: ( ) _____-_____

Email Address: _____

Physician – Name & Phone Number: _____ Pharmacy Phone Number: _____

Emergency Contact- Name & Phone Number: _____

How did you hear about our office? Doctor/Friend_____ Internet Insurance Other_____

Have you or your child been seen in any other dental office? Y N When & Where? _____

Are you in the care of an orthodontist? Y N When & Where? _____

Dental Insurance Information

Primary Insurance Carrier Name: _____

Subscriber Name: _____

Employer Name: _____

Insurance Phone Number: _____

Insurance ID: _____

Medical History

If you have ever had any of the following health problems please check Yes or No

	Yes	No		Yes	No
High Blood Pressure	____	____	Asthma	____	____
Low Blood Pressure	____	____	Emphysema	____	____
Adverse effects from dental treatment	____	____	Bronchitis	____	____
Heart Murmur	____	____	Pneumonia	____	____
Stroke	____	____	Tuberculosis	____	____
Pace Maker	____	____	Chronic Coughing	____	____
Angina	____	____	Seizures	____	____
Coronary Artery Disease	____	____	Convulsions	____	____
Heart Attack	____	____	Epilepsy	____	____
Palpitations	____	____	Fainting	____	____
Mitral Valve Prolapse	____	____	Dizziness	____	____
Bleeding Disorder	____	____	Panic Disorder	____	____
Anemia	____	____	Liver Disease	____	____
Blood Transfusion	____	____	Jaundice	____	____
Artificial Joints	____	____	Kidney Disease	____	____
Implants	____	____	Diabetes	____	____
Thyroid Disease (Goiter)	____	____	Arthritis	____	____
Stomach Ulcers / Colitis	____	____	Glaucoma	____	____
Radiation Treatments for Cancer	____	____	Nervous disorders	____	____
Rheumatic Fever	____	____	Down Syndrome	____	____
Autism	____	____	Asperger's Syndrome	____	____
ADD/ADHD	____	____	Cystic Fibrosis	____	____
Hepatitis	____	____	Prolonged Bleeding/Hemophilia	____	____
HIV/AIDS	____	____	Leukemia	____	____
Tumors or Malignancies	____	____	Mouth Injury	____	____
Food/Dye Allergies	____	____	Latex Allergy	____	____
Sinus/Nasal Problems	____	____			

Do you smoke or chew tobacco? Yes or No

Are you using any controlled substances? Yes or No

Do you use alcohol? Yes or No

For Women Only

Are you Pregnant? Yes or No

Are you nursing? Yes or No

Are you using oral contraceptives? Yes or No

Are you currently taking any medications? (Including over the counter):_____

Are you allergic or have had a bad reaction to any medications? _____

Have you had any hospitalizations/surgeries? If yes please list what and when? If you have been told you require pre medication before dental treatment please contact our office before your dental appointment:

_____

_____.

If you have had any heart problems/surgeries please list your cardiologist name and number: _____

If you have any problems not listed above please let a member of our staff know just as soon as possible. Please let us know if there are any contagious conditions that you may be experiencing Ex: Pink eye, poison ivy, Flu like symptoms etc.

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand the importance of a truthful health history to assist the doctor in providing the best care possible. It is my responsibility to inform the dental office of any changes in my medical status.

I hereby authorize Central Park Dental and/or dental staff to perform any necessary dental services that I may need.

I understand that insurance is a method of reimbursing the patient fees paid to the doctor and is not a substitute for payment. (Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge.) **I understand that is my responsibility to know my insurance plan and to obtain any required referrals and pay any deductible amount, coinsurance, or any other balance not paid for by my insurance**. **I understand that any estimates and insurance verification done by Central Park Dental is a courtesy and should not be mistaken as a guarantee of coverage.**

I hereby authorize payment made by the dental insurance company to be paid directly to Central Park Dental. I hereby authorize the dentist to release any information including the diagnosis and the records of any treatment to any third party payers and/or other health practitioners.

This authorization and release shall remain in effect until I give Central Park Dental notice in writing.

_____ _____

Signature Relationship to Patient

_____ _____

Print Name Date