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PLEASE COMPLETE BOTH SIDES OF FORM

Patient Information

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

☐ Male ☐ Female **I AM** ☐ Married ☐ Single ☐ Child ☐ Other

SS#: _____ DOB: _____ Email: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Address: _____
Street Apartment #

_____
City State Zip Code

Occupation: _____ Patient's Employer/School: _____

Spouse/Parent's Name: _____ Spouse/Parent's DOB: _____

Spouse/Parent's SS#: _____ Spouse/Parent's Employer: _____

Who is responsible for this account? _____ Relationship: _____

Does patient have dental insurance? ☐ Yes ☐ No

Name of Primary Insurance Holder: _____ DOB: _____

Dental Insurance Name & Address: _____

_____ Insurance ID# _____ Group# _____

Is patient covered by secondary insurance? ☐ Yes ☐ No

Name of Secondary Insurance Holder: _____ DOB: _____

Dental Insurance Name & Address: _____

_____ Insurance ID# _____ Group# _____

Whom may we thank for referring you to our office? _____

In Case of an Emergency Please Contact the Following:

Name: _____ Relationship: _____

Phone (cell): _____ (home): _____

Employer: _____ Work Phone: _____

Health Information

If you are new to our office, what was the date of your last dental visit: _____

Previous Dentist/Dentists:_____ Reason for today's visit?_____

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

- ◊ AIDS/HIV
- ◊ Allergies _____
- ◊ Arthritis
- ◊ Anemia
- ◊ **Artificial Heart Valve** _____
- ◊ **Artificial Joint Replacements** _____
- ◊ Asthma
- ◊ Blood Disease
- ◊ **Bone Medication**
- ◊ Cancer
- ◊ Chemical Dependency
- ◊ Diabetes
- ◊ Epilepsy
- ◊ **Excessive Bleeding**
- ◊ Glaucoma
- ◊ Liver Disease
- ◊ Head Injuries
- ◊ Heartburn - GERD
- ◊ Heart Disease
- ◊ Heart Murmur
- ◊ Hepatitis
- ◊ **High Blood Pressure**
- ◊ Kidney Disease
- ◊ Mental Disorders
- ◊ Nervous Disorders
- ◊ Osteoporosis
- ◊ Organ Transplants
- ◊ _____
- ◊ Pacemaker
- ◊ **Pregnant Now?** Due Date _____
- ◊ Rheumatism
- ◊ Radiation Treatment
- ◊ Respiratory Problems
- ◊ Rheumatic Fever
- ◊ Sexually Transmitted Disease
- ◊ Seasonal Allergies
- ◊ Sinus Problems
- ◊ Stroke
- ◊ Thyroid Problems
- ◊ Surgeries-Past/Future _____
- ◊ Smoking Habit How often? _____
- ◊ Tobacco Habit How often? _____
- ◊ Tuberculosis
- ◊ Tumors
- ◊ Ulcers
- ◊ **CODEINE ALLERGY**
- ◊ **PENICILLIN ALLERGY**
- ◊ **LATEX ALLERGY**
- ◊ **OTHER ALLERGIES**

ARE YOU CURRENTLY TAKING?

- ◊ **BLOOD THINNERS**
- ◊ **HEART MEDICATIONS**
- ◊ **BISPHOSPHONATES**

Have you every had any complications following dental treatment? If yes, please explain:

_____

List any medications, herbal supplements, or vitamins you are taking: (or provide a separate list)

_____

Are you seeing a physician or being treated for any medical problems? If yes. Please list Physician name & explain:

_____

Do you have any other medical problems or surgeries such as joint replacements, heart surgery, etc? Explain.

_____

Are you currently ill or have any mouth sores or lesions? If yes, please explain.

_____

Consent for Services

I am responsible to know my own dental insurance and benefits. X-rays and fluoride treatments will be done at the doctor's discretion. I agree to be responsible for all charges. Patients who have dental insurance authorize payments to be made directly to the doctor and the release of any information relating to claims. We will be glad to submit claims for you, however, you are ultimately responsible for the charges. I grant my permission for the office staff to contact me by phone, text, & mail messages regarding appointments. By signing this form, I give Sandusky Dental Partners the consent to use and disclose my protected health information to carry out treatment, payment activities, and healthcare operations.

To the best of my knowledge, all of the preceding information provided is true and correct. If I ever have any change in my health, I will inform the doctors at my next appointment without fail. I have read the above conditions of treatment and payment and agree to their consent.

_____

Signature of patient, parent, or guardian Date Relationship to Patient