FAIRMONT DENTAL ASSOCIATES

GENERAL AND COSMETIC DENTISTRY
COMPLETE ORAL CARE CENTER FOR YOU AND YOUR FAMILY

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to help you.

Patient Information

Date _____ Home Phone (_____) _____ Cell Phone (_____) _____

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ Email _____

City _____ State _____ Zip _____

Sex ❑ M ❑ F Age_____ Birth Date _____ ❑ Married ❑ Widowed ❑ Single ❑ Minor
❑ Separated ❑ Divorced ❑ Partnered for Years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (_____) _____

Whom may we thank for referring you? _____

In case of emergency, whom should be notified? _____ Phone (_____) _____

How did you hear about us?
Friend / Family Member: Name _____ Magazine: Name _____

Internet: Website _____

❑ Drove by / Saw your sign ❑ Other _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Middle Initial

Relationship to Patient _____ Birth Date _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (_____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (_____) _____

Insurance Company _____ _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Additional Insurance

Is Patient covered by Additional Insurance ? ❑ Yes ❑ No

Subscriber Name _____ Birth Date _____ Relationship to Patient _____

Address (If different from patient's) _____ Phone (_____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (_____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Dental History

Reason for Today's Visit _____ Date of last Dental Care _____

Former Dentist _____ Date of last Dental X-Rays _____

Address _____

Check (✓) if you have had problems with any of the following:

❑ Bad Breath	❑ Grinding Teeth	❑ Sensitivity to Hot
❑ Bleeding Gums	❑ Loose Teeth or Broken Fillings	❑ Sensitivity to Sweets
❑ Clicking or Popping Jaw	❑ Periodontal Treatment	❑ Toothache on Chewing
❑ Food Collection Between	❑ Sensitivity to Cold	❑ Sores / Growths in Mouth

How often do you Floss? _____ How often do you Brush? _____

Would you like to improve your smile? ❑ Yes ❑ No

What is it you do not like about your smile? _____

Medical History

Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "Fen-Phen" ? These include combinations of Lonimin, Adipex, Fastin (brand names of Phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ❑ Yes ❑ No

Have you had any serious illnesses or operations? ❑ Yes ❑ No If yes, give approximate dates _____

(Women) Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

Check (✓) if you have had any of the following:

❑ Anemia	❑ Cortisone Treatments	❑ Hepatitis	❑ Scarlet Fever
❑ Arthritis, Rheumatism	❑ Cough, Persistent	❑ High Blood Pressure	❑ Shortness of Breath
❑ Artificial Heart Valve	❑ Cough up Blood	❑ HIV / AIDS	❑ Skin Rash
❑ Artificial Joints	❑ Diabetes	❑ Jaw Pain	❑ Stroke
❑ Asthma	❑ Epilepsy	❑ Kidney Disease	❑ Swelling of Feet or Ankles
❑ Back Problems	❑ Fainting	❑ Liver Disease	❑ Thyroid Problems
❑ Blood Disease	❑ Glaucoma	❑ Mitral Valve Prolapse	❑ Tobacco Habit
❑ Cancer	❑ Headaches	❑ Pacemaker	❑ Tonsillitis
❑ Chemical Dependency	❑ Heart Murmur	❑ Radiation Treatment	❑ Tuberculosis
❑ Chemotherapy	❑ Heart Problems	❑ Respiratory Disease	❑ Ulcer
❑ Circulatory Problems	❑ Hemophilia	❑ Rheumatic Fever	❑ Venereal Disease

Check (✓) if you are Allergic to any of the following:

❑ Aspirin ❑ Codeine ❑ Dental Anesthetics ❑ Latex ❑ Penicillin ❑ Sulfa

❑ Other_____

MEDICATIONS (List Medications you are currently taking:) _____

_____

_____

MEDICAL UPDATES: _____

_____

_____

Authorization

I certify that I, and/or my dependent's, have Insurance Coverage with _____ and assign directly to

(Name of Insurance Company(ies))

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. 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.

The above named Dentist may use my healthcare information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please Print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED