5TH AVENUE DENTAL
Comprehensive Family Care

Welcome

PATIENT INFORMATION

Today's Date:_____ Email Address: _____

Name: _____ I prefer to be called: _____

☐ M ☐ F Birthdate:_____/_____/_____ Age: _____ SSN#: _____

Home Address: _____ City: _____ State: _____ Zip: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Home Phone: (___)_____ Cell Phone: (___)_____ Work Phone: (___)_____ Ext._____

Employer: _____ Address: _____

Length of Employment: _____ Occupation: _____

Where & when are the best times to reach you? _____

Whom may we Thank for referring you? _____ Other family members seen by us: _____

Previous/Present Dentist: _____ Date of Last Visit: _____
(Please Circle)

Emergency: In the event of an emergency, is there someone who lives near you that we should contact?

His/Her Name: _____ Relationship: _____ Wk#: (____)_____ Hm#: (____)_____

SPOUSE INFORMATION

His/Her Name: _____ Employer: _____

Work Phone: (___)_____ Ext: _____ Birth Date: ____/____/____ SS No: _____

PERSONAL RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____

Work Phone: (___)_____ Ext: _____ Home Phone: (___)_____

Employer: _____ Social Security No. _____

PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____ Address: _____

Phone No: (____)_____ Group Plan No. (Plan, Local or Policy#):_____

Insured's Name: _____ Relation: _____ SS No: _____

Birthdate: _____/_____/_____

Insured's Employer: _____ Employer's Address: _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____ Address: _____

Phone No: (____)_____ Group Plan No. (Plan, Local or Policy#):_____

Insured's Name: _____ Relation: _____ SS No._____ Birthdate: ____/____/____

Insured's Employer: _____ Employer's Address: _____

MEDICAL HISTORY

Do you have a physician? ☐ YES ☐ NO Physician's Name: _____

Address: _____ Phone No: (___)_____ Date of Last Visit: _____

MEDICAL HISTORY

PATIENT NAME: _____ BIRTH DATE: _____

Are you under a physician's care now?	O Yes O No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	O Yes O No	If yes, please explain: _____
Have you ever had a serious neck or head injury?	O Yes O No	If yes, please explain: _____
Are you taking any medications, pills or drugs?	O Yes O No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	O Yes O No	_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	O Yes O No	_____
Are you on a special diet?	O Yes O No	
Do you use tobacco?	O Yes O No	
Do you use controlled substance?	O Yes O No	

Women: Are you

Pregnant/Trying to get pregnant? O Yes O No Taking oral contraceptives? O Yes ONo Nursing? O Yes O No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	O Yes O No	Cortisone Medicine	O Yes O No	Hemophilia	O Yes O No	Radiation Treatments	O Yes O No
Alzheimer's Disease	O Yes O No	Diabetes	O Yes O No	Hepatitis A	O Yes O No	Recent Weight Loss	O Yes O No
Anaphylaxis	O Yes O No	Drug Addiction	O Yes O No	Hepatitis B or C	O Yes O No	Renal Dialysis	O Yes O No
Anemia	O Yes O No	Easily Winded	O Yes O No	Herpes	O Yes O No	Rheumatic Fever	O Yes O No
Angina	O Yes O No	Emphysema	O Yes O No	High Blood Pressure	O Yes O No	Rheumatism	O Yes O No
Arthritis/Gout	O Yes O No	Epilepsy or Seizures	O Yes O No	High Cholesterol	O Yes O No	Scarlet Fever	O Yes O No
Artificial Heart Valve	O Yes O No	Excessive Bleeding	O Yes O No	Hives or Rash	O Yes O No	Shingles	O Yes O No
Artificial Joint	O Yes O No	Excessive Thirst	O Yes O No	Hypoglycemia	O Yes O No	Sickle Cell Disease	O Yes O No
Asthma	O Yes O No	Fainting Spells/Dizziness	O Yes O No	Irregular Heartbeat	O Yes O No	Sinus Trouble	O Yes O No
Blood Disease	O Yes O No	Frequent Cough	O Yes O No	Kidney Problems	O Yes O No	Spina Bifida	O Yes O No
Blood Transfusion	O Yes O No	Frequent Diarrhea	O Yes O No	Leukemia	O Yes O No	Stomach/Intestinal Disease	O Yes O No
Breathing Problem	O Yes O No	Frequent Headaches	O Yes O No	Liver Disease	O Yes O No	Stroke	O Yes O No
Bruise Easily	O Yes O No	Genital Herpes	O Yes O No	Low Blood Pressure	O Yes O No	Swelling of Limbs	O Yes O No
Cancer	O Yes O No	Glaucoma	O Yes O No	Lung Disease	O Yes O No	Thyroid Disease	O Yes O No
Chemotherapy	O Yes O No	Hay Fever	O Yes O No	Mitral Valve Prolapse	O Yes O No	Tonsillitis	O Yes O No
Chest Pains	O Yes O No	Heart Attack/Failure	O Yes O No	Osteoporosis	O Yes O No	Tuberculosis	O Yes O No
Cold Sores/Fever Blisters	O Yes O No	Heart Murmur	O Yes O No	Pain in Jaw Joints	O Yes O No	Tumors or Growth	O Yes O No
Congenital Heart Disorder	O Yes O No	Heart Pacemaker	O Yes O No	Parathyroid Disease	O Yes O No	Ulcers	O Yes O No
Convulsions	O Yes O No	Heart Trouble/Disease	O Yes O No	Psychiatric Care	O Yes O No	Venereal Disease	O Yes O No
						Yellow Jaundice	O Yes O No

Have you ever had any serious illness not listed above? O Yes O No _____

Are you interested in a nonsurgical way to stop your spouse from snoring? O Yes O No

Comments: _____

_____

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointment without prior notification of 48 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for the patient.

INSURANCE: To avoid misunderstandings regarding dental insurance, we would like to inform the persons responsible that all professional services rendered are charged directly to them and that they are personally responsible for payment of fees. We will prepare necessary forms or reports tc help the persons responsible to obtain benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any change in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN_____DATE:_____