## PATIENT INFORMATION

Patient's name _____ Preferred name _____ Birth date_____

If minor, parents names _____ Cell phone _____ Home phone _____

Mailing address _____ City _____State _____ Zip _____

**INSURANCE INFORMATION** ❑ Not covered by dental insurance

Primary Policy Holder : ❑ Self ❑ Spouse Spouse's name _____

Primary's Employer _____ Occupation_____

Primary's Social number: _____ Dental Insurance Co._____ Group number_____

**As a courtesy to our patients, we will submit insurance claims on your behalf. Please understand that all fees are estimated based on information provided by the insurance, and is not a guarantee of payment by them. In the event that the insurance company does not pay their estimated portion, the patient will be responsible for that amount.**

I authorize dental insurance payments (assignment of benefits) to the offices of State 48 Dental. _____(initials)

## MEDICAL HEALTH HISTORY

Check Yes or No if you've ever been diagnosed with the following:

**Yes No**

O O Cancer: Type/year/status: _____
O O Heart attack (year _____) or ❑ Angina (chest pain)
O O Heart Valve Replacement (year _____)
O O Rheumatic fever or rheumatic heart disease
O O Congestive Heart Failure (CHF)
O O Pacemaker
O O High blood pressure ❑ Low blood pressure
O O Total Joint Replacement (Knees, Hips, or Other)
O O Bleeding (clotting) Disorder
O O COPD (Bronchitis/Emphysema)
O O Tuberculosis (even if inactive)
O O Kidney/Renal Disease ❑ Dialysis
O O Hepatitis (Type: ) ❑ Other liver disease
O O Diabetes (Type: )
O O Neuroloic/Nerve Condition
O O Seizures (Type: )
O O Depression or Mood Disorder (Type: _____
O O Arthritis (Rheumatoid or Osteoarthritis)
O O Herpes/Cold Sores
O O AIDS or HIV positive
O O Headache disorders
O O Anemia
O O Sinusitis
O O Thyroid (Hyper or Hypo)
O O Asthma

O O Alcoholism ❑ Drug addiction (Type: )
O O Smoking or chewing tobacco
- ❑ Current usage: Packs per day _____.
- ❑ Previous usage: # of Years usage before quitting:___.
  - ❑ Avg packs per day before quitting _____.

Women:

O O Pregnant: Expected delivery date: _____
O O Possibly pregnant
O O Taking hormones or contraceptives

Please list any other medical conditions you may have:

_____.
_____.
_____

Physician Name & Phone: _____.

_____.

Do you have a TRUE **ALLERGY** to any of the following?
(TRUE - difficulty breathing, swelling, severe rash/itching)

- ❑ Latex
- ❑ Penicillin ❑ Other antibiotics
- ❑ Local Anesthesia (Lidocaine)
- ❑ Codeine ❑ Hydrocodone
- ❑ Sulfa drugs
- ❑ Aspirin
- ❑ Other:_____

Please list **MEDICATIONS** you are taking:

_____.
_____.
_____.
_____.
_____.
_____.

❑ I did not list all medications

Have you ever had Bisphosphonate Drug Therapy ?
(medicine for osteoporosis or bone cancer) ❑ Yes ❑ No

Please Tell us about your **DENTAL CONCERNS**:

_____.
_____.
_____.
_____.

Appointment Cancellation Policy

Due to the high cost of healthcare, Our office requires a minimum of 24-48 hour notice for appointment cancellation or rescheduling. A $50 fee may be charged for non compliance.

Patient (or Parent) Signature:

_____.

Date: _____