WELCOME TO FRIENDLY FAMILY DENTAL!

Thank you trusting us with your dental care. We promise to do our best to provide you with the finest care available. It is important for you to fill out the following pages completely and accurately so we can provide you with customized care tailored to your needs.
If you have any questions, please do not hesitate to ask us!

PATIENT INFORMATION

Name:_____ Birthdate: _____ Email Address:_____

Address:_____ City & State:_____ Zip Code: _____

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

Sex: M / F Marital Status: Married / Divorced / Single / Minor / Separated / Widowed / Partnered for __ yrs

Social Security #:_____ Driver's License #:_____

Name and Phone # of emergency contact:_____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

Name of Insured:_____ **Relation to Patient**: _____

Address:_____ City & Zip Code :_____ State:____

Phone #: _____

Birthdate of Insured: _____ **Social Security # of Insured**:_____

Employer: _____

Employer Address: _____ City & Zip Code:_____

Insurance Company: _____ **Group Name: _____**

Group #:_____

Subscriber ID of Insured: _____

Have you used any Dental benefits at another office this year? _____

☐ Check here if you have an additional/secondary insurance you would like us to bill.

DENTAL HISTORY

My reason for today's visit is: _____ Date of last dental care: _____

Former Dentist: _____ Reason for leaving last dentist:_____

Check if you have any of the following:

___	Bad Breath	___	Sensitivity to sweets	Any other concerns? _____
___	Bleeding gums	___	Sensitivity to biting	_____
___	Clicking or popping jaw	___	Sores or growths in your mouth	History of unrealistic expectations
___	Food collecting between teeth	___	Discolored teeth	related to cosmetics or healthcare?
___	Grinding Teeth	___	Ill-Fitting Dentures	Y / N
___	Loose teeth or broken fillings	___	Crowded teeth	
				How often do you:
___	Periodontal treatment	___	Cosmetically unhappy with your teeth	Floss: _____
___	Sensitivity to cold	___	Bad taste in mouth	Brush: _____
___	Sensitivity to hot	___	Braces in the past	Use Mouth rinse:_____

MEDICAL HISTORY

Physician's Name: _____ Phone #:_____Date of last visit:_____

Have you had any serious illness or operations? ☐ Yes ☐ No If yes, describe: _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates: _____

Women: Are you pregnant or might be pregnant? Y / N Expected delivery date:_____

Nursing? Y / N Taking Birth Control Pills Y / N

Please note if you are pregnant or think you may be it is very important to mention this to your dental staff and Doctor before we start any treatment. Some treatment may need to be postponed until your 2nd trimester or per the Doctor's determination.

Check if you have any of the following:

Y / N Anemia
Y / N Arthritis, rheumatism
Y / N Artificial Heart Valves
Y / N Asthma
Y / N Back problems
Y / N Blood Disease
Y / N Cancer
Y / N Drug Dependency
Y / N Chemotherapy
Y / N Circulatory problems
Y / N Congenital Heart Lesions
Y / N Persistent Cough
Y / N Diabetes
Y / N Epilepsy
Y / N Fainting Spells
Y / N Glaucoma

Y / N Persistent Headaches
Y / N Heart Murmur
Y / N Heart Problems
Y / N Hemophilia
Y / N Hepatitis
Y / N High Blood Pressure
Y / N HIV/AIDS
Y / N Jaw Pain
Y / N Kidney Disease
Y / N Liver Disease
Y / N Mitral Valve Prolapse
Y / N Pacemaker
Y / N Radiation Treatment
Y / N Respiratory Disease
Y / N Rheumatic Fever
Y / N Scarlet Fever

Y / N Shortness of Breath
Y / N Skin Rash
Y / N Stroke
Y / N Swelling of Feet or Ankles
Y / N Thyroid Problems
Y / N Tobacco: chew / smoke
Y / N Tonsillitis
Y / N Tuberculosis
Y / N Ulcers
Y / N Venereal Disease
Y / N Latex Allergy
Any other health conditions not listed above? Y / N
Please specify if Yes: _____
_____
_____

CURRENT MEDICATIONS	DOSAGE	REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____

Feel free to attach a copy of your medication list if more space is needed

ALLERGIES:_____ Check here if NO KNOWN ALLERGIES ☐

Do you currently have or have you had outbreaks of herpes or cold sores? Y / N

*Please note that if you currently have an outbreak of cold sores on your lips or anywhere in your mouth it is advised that you postpone any dental treatment, x-rays, or cleanings until it has cleared up for your own safety to prevent the outbreak from spreading and infecting other parts of your face.

Have you had any adverse reactions in the past to local anesthetics/dental shots ("novocaine"/lidocaine with epinephrine) such as heart racing or increased blood pressure? Y / N

If you have asthma, it is advised that you keep your inhaler with you at all appointments and keep it in reach at all times during your appointment.

If you have had any heart surgery it is advised that you inform the Doctor so she may contact your physician as needed. It is advised to postpone dental treatment for 6 months after any heart procedure.

If you have had any joint replacements you must inform the Doctor.

Please be advised that if you currently have a cold, flu, bad cough, sinus or respiratory issues it is advised that you postpone treatment until you feel better for your own safety and for the safety of our other patients.

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I will not hold the doctor liable for any adverse reactions if any medical conditions or allergies have not been selected above.
I certify that I, and/or my dependent(s), have insurance coverage as noted above. I understand that I am financially responsible for all charges whether or not paid by my insurance. Friendly Family Dental will bill my insurance on my behalf; however, in situations where insurance deny payment, I understand I will be held responsible for the full amount of my treatment. I authorize Friendly Family Dental use of my health care information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative | Date

_____ _____

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