WELCOME

PARK DENTAL GROUP, LLC

ADULT PATIENT INFORMATION FORM

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

ABOUT YOU

Today's Date _____

Email Address _____

NAME _____
LAST FIRST MI TITLE

I prefer to be called _____ ☐ Male ☐ Female

Birthday ___ / ___ / ___ Age _____ SS # _____

HOME ADDRESS _____
STREET APT/CONDO #

_____
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home # _____ Cell # _____

Work # _____ EXT ___ DL # _____

EMPLOYER _____

Employer's Address _____

Years at current job ____ Occupation _____

When & where are the best times to reach you? _____

_____

Whom may we thank for referring you? _____

Other family members seen by us _____

Previous / Present Dentist _____
PLEASE CIRCLE ONE

Date of Last Visit _____

SPOUSE INFORMATION

His/Her Name _____

Employer _____

Work # _____ EXT ___ SS # _____

Birthday ___ / ___ / ___ DL # _____

PERSON RESPONSIBLE FOR ACCOUNT

Work # _____ EXT ____ Home # _____

Billing Address _____

_____

Relationship _____ SS # _____

Employer _____ DL # _____

DENTAL INSURANCE

PRIMARY DENTAL INSURANCE

Do you have Dental Coverage? ☐ Yes ☐ No

INSURANCE CO. NAME _____

Address _____

Phone # _____

Group # (Plan, Local or Policy #) _____

INSURED'S NAME _____

Relation _____ Insured's Birthday ___ / ___/ ___

Insured's ID # _____

Insured's Employer _____

Employer's Address _____

SECONDARY DENTAL INSURANCE

Do you have Dental Coverage? ☐ Yes ☐ No

INSURANCE CO. NAME _____

Address _____

Phone # _____

Group # (Plan, Local or Policy #) _____

INSURED'S NAME _____

Relation _____ Insured's Birthday ___ / ___/ ___

Insured's ID # _____

Insured's Employer _____

Employer's Address _____

NEIGHBOR OR RELATIVE NOT LIVING WITH YOU

Name _____ Relation _____

Home # _____ Work # _____

Address _____

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name _____

Phone # _____ Date of last visit _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain _____

When describing recommended treatments, do you prefer more or less detail? _____

ADULT PATIENT INFORMATION FORM CONTINUED

MEDICAL HISTORY (CONTINUED)

CURRENT PHYSICAL HEALTH IS Good Fair Poor

Do you smoke or use tobacco in any form? Yes No

Have you had any metal rods, pins or implants? Yes No

Are you taking any prescription/over-the-counter or herbal supplemental drugs? Yes No

Please list each one_____

Have you ever taken Fosamax, or any other bisphosphonate? Yes No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? Yes No

FOR WOMEN Are you using a prescribed method of birth control?

Are you pregnant? Yes No Week #_____

Are you nursing? Yes No

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS

Y	N	Abnormal Bleeding	Y	N	Herpes / Fever Blisters
Y	N	Alcohol/Drug Abuse	Y	N	High Blood Pressure
Y	N	Anemia	Y	N	HIV+ / AIDS
Y	N	Arthritis	Y	N	Hospitalized for Any Reason
Y	N	Artificial Bones / Joints / Valves	Y	N	Kidney Problems
Y	N	Asthma	Y	N	Liver Disease
Y	N	Blood Transfusion	Y	N	Low Blood Pressure
Y	N	Cancer / Chemotherapy	Y	N	Lupus
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Osteoporosis / Paget's Disease
Y	N	Diabetes	Y	N	Pacemaker
Y	N	Difficulty Breathing	Y	N	Psychiatric Treatment
Y	N	Emphysema	Y	N	Radiation Treatment
Y	N	Epilepsy	Y	N	Rheumatic / Scarlet Fever
Y	N	Fainting Spells	Y	N	Seizures
Y	N	Frequent Headaches	Y	N	Shingles
Y	N	Glaucoma	Y	N	Sickle Cell Disease / Traits
Y	N	Hay Fever	Y	N	Sinus Problems
Y	N	Heart Attack	Y	N	Stroke
Y	N	Heart Murmur	Y	N	Thyroid Problems
Y	N	Heart Surgery	Y	N	Tuberculosis (TB)
Y	N	Hemophilia	Y	N	Ulcers
Y	N	Hepatitis	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had: _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Y	N	Aspirin	Y	N	Latex
Y	N	Codeine	Y	N	Penicillin
Y	N	Dental Anesthetics	Y	N	Tetracycline
Y	N	Erythromycin	Y	N	Other

Please list any other drugs/materials that you are allergic to:

_____

DENTAL HISTORY

WHY HAVE YOU COME TO THE DENTIST TODAY?

_____

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had a serious / difficult problem associated with any previous dental work? Yes No

Do you have fears about going to the dentist? Yes No

Have you ever had gum treatment? Yes No

DO YOU NOW OR HAVE YOU EVER EXPERIENCED PAIN / DISCOMFORT IN YOUR JAW JOINT (TMJ/TMD)?

Your current dental health is Good Fair Poor

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

How many times a week do you floss?_____

How many times a day to you brush?_____

Type of bristles? Soft Medium Hard

How long do you use a toothbrush before replacing it?_____

Are your teeth sensitive to heat, cold, or anything else?_____

_____

Have you lost any teeth? Yes No If yes, why?_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature_____ Date _____

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT

(unless prior arrangements have been approved)

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature_____ Date _____

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials _____ Date _____

Doctor's Comments _____

MEDICAL HISTORY UPDATE

I have read my medical history dated_____and confirmed that it states past and present medical conditions Signature_____Date_____

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