FORD AVENUE FAMILY
DENTISTRY

PATIENT MEDICAL/DENTAL HISTORY

Welcome to our office!! We will do our best to make your appointments as convenient and pleasant as possible. If at any time you have any questions regarding your treatment, your appointments, or our fees, please feel free to ask. In order to safeguard your health, it is important that you answer the following questions. Please remember that these questions are held in strict confidence.

Date: _____
Patient's Name: _____ Birthdate: _____
Street Address: _____ City/State/Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email Address: _____ SS#: _____
Employer: _____Occupation:_____
Responsible Party of Patient: _____Relationship to Patient: _____
Contact Phone: _____ Alternate Phone: _____SS#: _____
How did you hear about us? _____

PATIENT MEDICAL HISTORY

Please check YES or NO to the following questions.

1. Are you currently under the care of a physician? ..... □YES □ NO
   If YES, please explain: _____
2. Have you been hospitalized within the past 5 years? ..... □YES □ NO
   If YES, please explain: _____
3. Have you had any major operations? ..... □YES □ NO
   If YES, please explain: _____
   _____
4. Have you had surgery or x-ray treatment for a tumor or growth? ..... □YES □ NO
   If YES, please explain: _____
5. Are you employed anywhere that exposes you to x-rays or ionizing radiation? ..... □YES □ NO
6. Are you allergic to any medicines or drugs? ..... □YES □ NO
   If YES, please list allergy and reaction: _____
   _____
7. Are you currently taking any prescription drugs or supplements? ..... □YES □ NO
   If YES, please list medications and indications: _____
   _____
8. Have you ever had a blood transfusion? ..... □YES □ NO
9. Have you ever had a bad reaction to local anesthetic? ..... □YES □ NO
   If YES, please describe: _____
10. Do you require premedication before dental treatment? ..... □YES □ NO
11. Have you had any kind of plastic surgery? ..... □YES □ NO
    If YES, please explain: _____
12. Have you had bisphosphonate therapy? ..... □YES □ NO
    If YES, please list which kind: _____
13. Do you take aspirin or blood thinners daily? ..... □YES □ NO
14. Have you ever been tested for HIV/AIDS? ..... □YES □ NO
    If YES, what was the result? ..... □POSITIVE □ NEGATIVE
15. Are you in good health at this time? ..... □YES □ NO
16. WOMEN ONLY: Are you pregnant? ..... □YES □ NO □UNSURE
    Are you currently nursing? ..... □YES □ NO
    Are you taking any form of birth control? ..... □YES □ NO

17. Are you allergic to any of the following?

Local Anesthetic	□YES □ NO	Aspirin	□YES □ NO	Codeine	□YES □ NO
Penicillin	□YES □ NO	Sedatives	□YES □ NO	Sulfa Drugs	□YES □ NO
Tetracycline	□YES □ NO	Erythromycin	□YES □ NO	Latex	□YES □ NO

Please indicate which of the following you have presently or experienced in the past.
Please check YES or NO

AIDS/HIV Positive	☐ YES ☐ NO	Drug Addiction	☐ YES ☐ NO	Psychiatric Care	☐ YES ☐ NO
Alcoholism	☐ YES ☐ NO	Emphysema	☐ YES ☐ NO	Radiation	☐ YES ☐ NO
Anaphylaxis	☐ YES ☐ NO	Epilepsy/Seizures	☐ YES ☐ NO	Rheumatic Fever	☐ YES ☐ NO
Anemia	☐ YES ☐ NO	Fainting/Dizzy Spells	☐ YES ☐ NO	Sickle Cell Disease	☐ YES ☐ NO
Arthritis	☐ YES ☐ NO	Glaucoma	☐ YES ☐ NO	Sinus Problems	☐ YES ☐ NO
Artificial Joints	☐ YES ☐ NO	Hay Fever	☐ YES ☐ NO	Stress	☐ YES ☐ NO
Artificial Valves	☐ YES ☐ NO	Heart Murmur	☐ YES ☐ NO	Stroke	☐ YES ☐ NO
Asthma	☐ YES ☐ NO	Heart Problems	☐ YES ☐ NO	Thyroid Disease	☐ YES ☐ NO
Allergies	☐ YES ☐ NO	Hemophilia	☐ YES ☐ NO	Tobacco Use	☐ YES ☐ NO
Bruise Easily	☐ YES ☐ NO	Herpes	☐ YES ☐ NO	Tonsillitis	☐ YES ☐ NO
Cancer	☐ YES ☐ NO	Hepatitis A/B	☐ YES ☐ NO	Tuberculosis	☐ YES ☐ NO
Chemotherapy	☐ YES ☐ NO	High Blood Pressure	☐ YES ☐ NO	Ulcer/Colitis	☐ YES ☐ NO
Circulatory Problems	☐ YES ☐ NO	Kidney Problems	☐ YES ☐ NO	Venereal Disease	☐ YES ☐ NO
Congenital Heart Lesions	☐ YES ☐ NO	Latex Allergy	☐ YES ☐ NO	Yellow Jaundice	☐ YES ☐ NO
Cold Sores/Fever Blister	☐ YES ☐ NO	Mitral Valve Prolapse	☐ YES ☐ NO		
Cortisone Medications	☐ YES ☐ NO	Nervousness	☐ YES ☐ NO		
Diabetes	☐ YES ☐ NO	Pacemaker	☐ YES ☐ NO		
Difficulty Breathing	☐ YES ☐ NO	Persistent Cough	☐ YES ☐ NO		

Do you have any medical conditions/concerns that the doctor should know about before your appointment? If YES, please explain: _____

_____

_____

PATIENT DENTAL HISTORY

What are you hoping to accomplish at your dental visit today? _____

_____

Do you have any special concerns regarding your visit? (Fear/Time/Money/Tension): _____

_____

Describe any previous problems you may have had with past dental treatment or special areas of concern that you would like to have addressed by our doctors and staff. _____

_____

Please indicate which of the following you have presently or experienced in the past.
Please check YES or NO

Abscess in mouth	☐ YES ☐ NO	Dry mouth	☐ YES ☐ NO
Any food traps	☐ YES ☐ NO	Gag easily	☐ YES ☐ NO
Bad breath	☐ YES ☐ NO	Infections in gums	☐ YES ☐ NO
Bad tastes	☐ YES ☐ NO	Loose teeth	☐ YES ☐ NO
Bite Nails	☐ YES ☐ NO	Missing teeth	☐ YES ☐ NO
Bleeding gums	☐ YES ☐ NO	Pain in jaw/ears	☐ YES ☐ NO
Blisters	☐ YES ☐ NO	Sensitive gums	☐ YES ☐ NO
Chew Tobacco	☐ YES ☐ NO	Sensitive teeth	☐ YES ☐ NO
Clenching/Grinding	☐ YES ☐ NO	Smoke	☐ YES ☐ NO
Cold Sores	☐ YES ☐ NO	Stained teeth	☐ YES ☐ NO
Difficulty chewing	☐ YES ☐ NO	TMJ problems	☐ YES ☐ NO

PHOTOGRAPHS/DIAGNOSTIC PHOTOS

I hereby authorize the office of Ford Avenue Family Dentistry to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Ford Avenue Family Dentistry to make a thorough diagnosis of my dental health and condition.

Please display consent by initializing: _____

In addition, I consent and authorize Ford Avenue Family Dentistry to use my name, photographs, video slides, or any other image as may be necessary of me, with or without my given name for marketing, education, or any other lawful purpose and I release and forever discharge him from any claim, demands, or liability on account of such use or for the quality of the reproduction of the photograph or photocopy provided.

Please display consent by initialing: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of the NOTICE OF PRIVACY PRACTICES of this office.

_____
Please Print Name

_____ _____
Signature Date

OFFICE USE ONLY

We tried to obtain written acknowledgement by the individual noted above the receipt of our NOTICE OF PRIVACY PRACTICES, but it could not be obtained because:

_____ An emergency prevented us from obtaining acknowledgement.
_____ A communication barrier prevented us from obtaining acknowledgement.
_____ The individual was unwilling to sign.
_____ Other

PAYMENT POLICY

In compliance with the Truth In Lending Law here is our credit policy:

It is customary to take care of all fees at the time services are rendered unless other arrangements have been made. To assist you with this we accept VISA and MasterCard Credit Cards.

Please display consent by initialing: _____

INSURANCE INFORMATION

Are you covered by any kind of dental insurance? ……..... □YES □ NO
Policy Holder: _____ Relationship to patient: _____
Policy Holder's Date of Birth: _____ SS#: _____
Address (if different from patient): _____
City:_____ State: _____Zip:_____
Policy Holder's Employer: _____ Occupation: _____
Business Address: _____ Business Phone: _____
Insurance Company: _____ Contact Phone:_____
Address: _____ City: _____State: _____
Identification #: _____ Group #: _____Subscriber #: _____
Name of other dependents covered under this plan: _____
_____
_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____
_____ and assign directly to
(Name of Insurance Company)
Ford Avenue Family Dentistry 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 dental practice may use my health care information and may disclose such information to the abovenamed Insurance Company 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/Guardian/Parent/Personal Representative Date

_____ _____
Print Name of Patient/Guardian/Parent/Personal Representative Relationship to Patient