FAMILY MEDICAL CENTERS

Welcome to the Family Medical Centers Dental Office

Name: _____ Sex ☐ M ☐ F DOB: _____ Age:_____

Address:_____
Street City State Zip

Medical Insurance:_____ Dental Insurance:_____

Check if the patient has or has had any of the following:

☐Anemia
☐Arthritis, Rheumatism
☐Artificial Heart Valves
☐Artificial Joints
☐Asthma
☐Back Problems
☐Bleeding or Clotting Abnormality
☐Blood Disease
☐Birth Defects or Genetic Disorders
☐Bone/Joint Problems
☐Cancer
☐Chemical Dependency
☐Chemotherapy
☐Circulatory Problems
☐Congenital Heart Lesions
☐Cortisone Treatment
☐Cough, Persistent
☐Cough up Blood
☐Cleft Lip or Palate
☐Cerebral Palsy
☐Diabetes
☐Developmentally Disabled
☐Epilepsy/Seizures
☐Ear or Hearing Problems
☐Fainting
☐Feeding or Eating Disorders
☐Gastric Reflux
☐Growth Problems
☐Headaches
☐ Heart Murmur
☐ Heart Problems
☐ Hemophilia
☐ Hepatitis or Liver Disease
☐ High Blood Pressure
☐ HIV/AIDS
☐ Kidney Disease
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Radiation Treatment
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Shortness of Breath
☐ Skin Rash
☐ Stents/Shunts
☐ Sickle Cell Anemia
☐ Stroke
☐ Swelling of Feet/Ankles
☐ Thyroid Problems
☐ Tonsillitis
☐ Tuberculosis
☐ Ulcer
☐ Venereal Disease
☐ Vision Problems
☐ Other Medical Problems
(Specify) _____
_____

Physician's Name:_____ Date of last visit:_____
Physician's Address:_____ Phone: _____
List of Medications, Dosage, and Correlating Diagnosis: _____
_____
_____
_____

Any allergies? ☐ Yes ☐ No If yes, please list:_____
Hospitalization? ☐ Yes ☐ No If yes, please list when and reason:_____
ER Visits? ☐ Yes ☐ No If yes please list when and reason:_____
Blood transfusion? ☐ Yes ☐ No If yes, please list when:_____

Is there any additional medical information that you would like to report? _____
_____
_____

Pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Dental History

Reason for today's visit: _____ Date of last dental visit: _____
Former Dentist Phone No. _____
Date of last dental x-ray? _____

Check if you have had any of the following:

☐ Bad Breath	☐ Sensitivity to Cold	☐ Toothache/Pain
☐ Bleeding Gums	☐ Sensitivity to Sweets	☐ Injuries to Mouth or Teeth
☐ Clicking or Popping of Jaw	☐ Sensitivity to Biting	☐ Abscesses (Gum Boils)
☐ Grinding Teeth	☐ Food Collection Between Teeth	☐ Other (Specify)
☐ Periodontal Treatment	☐ Loose teeth or broken fillings	
☐ Sensitivity to Hot	☐ Sores or Growths in Mouth	

CHILDREN ONLY

What school does child attend?_____
Finger or thumb sucking? ☐ Yes ☐ No
At what age did bottle or breast feeding stop?_____
Who is responsible for brushing the child's teeth?_____
What is the source of the patient's current drinking water supply? ☐ City ☐ Home well ☐ Bottled ☐ Don't know
Does the patient use a fluoride rinse at home or school? ☐ Yes ☐ No
Are the patient's immunization? ☐ Yes ☐ No
Do you think the child will cooperate for dental treatment? ☐ Yes ☐ No
Has the child had a bad or fearful dental or medical experience? ☐ Yes ☐ No
Which of the following best describes the child? ☐ Advanced in learning ☐ Progressing normally ☐ Slow learner
Does the patient have any history of emotional or behavioral problems? ☐ Yes ☐ No Specify_____
Are there any cultural, religious, or ethnic concerns that could affect the care of your child? ☐ Yes ☐ No
Names and ages of other children living within your family_____
Is there any additional information we should know? ☐ Yes ☐ No

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 or medications. I certify that I, and/or my dependents, currently have the insurance coverage indicated above and assign directly to this dental center all 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.
This dental center may use my health care information and may disclose such information to my insurance center and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for elated services. This consent will remain active until I revoke these rights in writing.

_____

Signature of Patient, Parent Guardian Date

_____

Please PRINT name of Patient, Parent, Guardian Relationship to Patient

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.