SPECIAL DENTAL CARE

"Anesthesia Powered Dentistry"

ABOUT YOU

Today's Date: _____

Name: _____
Last First M.I.

I prefer to be called: _____

☐ M
☐ F

☐ Mr.
☐ Mrs.
☐ Ms.
☐ Miss
☐ Dr.
☐ Minor

Birthdate: _____ **DL:** _____ **SS#:** _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

RESPONSIBLE PARTY ☐ **Self** ☐ **Parent** ☐ **Spouse** ☐ **Other**

Name: _____
First Last M.I.

Birthdate: _____ **DL#:** _____ **SS#:** _____

Home Address: _____

_____
City State Zip Code

Home Phone: _____ **Cell #:** _____

Work Phone: _____ **Email:** _____

Emergency Contact: Name_____

Relationship _____

Phone (_____)_____

MEDICAL INSURANCE

Coverage Type: ☐ PPO ☐ HMO ☐ Medical ☐ Other

Subscriber Name: _____

Birthdate: _____ **SS#:** _____

Member ID: _____ **Group #:** _____

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: _____

Do you have a personal physician? ☐ Yes ☐ No

Physician Name: _____

Phone #: _____ Date of last visit: _____

DENTAL INSURANCE: PRIMARY

Coverage Type: ☐ PPO ☐ HMO ☐ Denti-Cal ☐ Other

Subscriber Name: _____

Birthdate: _____ **SS#:** _____

Member ID: _____ **Group #:** _____

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: _____

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip Code

Employer's Phone #: (_____)_____

DENTAL INSURANCE: SECONDARY

Coverage Type: ☐ PPO ☐ HMO ☐ Denti-Cal ☐ Other

Subscriber Name: _____

Birthdate: _____ **SS#:** _____

Member ID: _____ **Group #:** _____

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: _____

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip Code

Employer's Phone #: (_____)_____

MEDICAL HISTORY

Are you under a physician's care now? ☐ Y ☐ N
Have you ever been hospitalized or had a major operation? ☐ Y ☐ N
Have you ever had a serious head or neck injury? ☐ Y ☐ N
Are you taking any medications, pills, or drugs? ☐ Y ☐ N
List all medications _____
Do you take, or have you taken, Phen-Fen or Redux? ☐ Y ☐ N
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Y ☐ N
Are you on a special diet? ☐ Y ☐ N
Do you use tobacco? ☐ Y ☐ N
Do you use controlled substances? ☐ Y ☐ N

Are you allergic to any of the following?

☐ Aspirin ☐ Pencillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Other _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	☐ Y ☐ N	Hemophilia	☐ Y ☐ N
Alzheimer's Disease	☐ Y ☐ N	Hepatitis A	☐ Y ☐ N
Anaphylaxis	☐ Y ☐ N	Hepatitis B or C	☐ Y ☐ N
Anemia	☐ Y ☐ N	Herpes	☐ Y ☐ N
Angina	☐ Y ☐ N	High Blood Pressure	☐ Y ☐ N
Arthritis/Gout	☐ Y ☐ N	High Cholesterol	☐ Y ☐ N
Artificial Heart Valve	☐ Y ☐ N	Hives or Rash	☐ Y ☐ N
Artificial Joint	☐ Y ☐ N	Hypoglycemia	☐ Y ☐ N
Asthma	☐ Y ☐ N	Irregular Heartbeat	☐ Y ☐ N
Blood Disease	☐ Y ☐ N	Kidney Problems	☐ Y ☐ N
Blood Transfusion	☐ Y ☐ N	Leukemia	☐ Y ☐ N
Breathing Problem	☐ Y ☐ N	Liver Disease	☐ Y ☐ N
Bruise Easily	☐ Y ☐ N	Low Blood Pressure	☐ Y ☐ N
Cancer	☐ Y ☐ N	Lung Disease	☐ Y ☐ N
Chemotherapy	☐ Y ☐ N	Mitral Valve Prolapse	☐ Y ☐ N
Chest Pains	☐ Y ☐ N	Osteoporosis	☐ Y ☐ N
Cold Sores	☐ Y ☐ N	Pain in Jaw Joints	☐ Y ☐ N
Congenital Heart Dz	☐ Y ☐ N	Parathyroid Disease	☐ Y ☐ N
Convulsions	☐ Y ☐ N	Psychiatric Care	☐ Y ☐ N
Cortisone Medicine	☐ Y ☐ N	Radiation Treatments	☐ Y ☐ N
Diabetes	☐ Y ☐ N	Recent Weight Loss	☐ Y ☐ N
Drug Addition	☐ Y ☐ N	Renal Dialysis	☐ Y ☐ N
Easily Winded	☐ Y ☐ N	Rheumatic Fever	☐ Y ☐ N
Emphysema	☐ Y ☐ N	Rheumatism	☐ Y ☐ N
Epilepsy/Seizures	☐ Y ☐ N	Scarlet Fever	☐ Y ☐ N
Excessive Bleeding	☐ Y ☐ N	Shingles	☐ Y ☐ N
Excessive Thirst	☐ Y ☐ N	Sickle Cell Disease	☐ Y ☐ N
Fainting Spells	☐ Y ☐ N	Sinus Trouble	☐ Y ☐ N
Frequent Cough	☐ Y ☐ N	Spina Bifida	☐ Y ☐ N
Frequent Diarrhea	☐ Y ☐ N	Stomach/Intestinal Dz	☐ Y ☐ N
Frequent Headaches	☐ Y ☐ N	Stroke	☐ Y ☐ N
Genital Herpes	☐ Y ☐ N	Swelling of Limbs	☐ Y ☐ N
Glaucoma	☐ Y ☐ N	Thyroid Disease	☐ Y ☐ N
Hay Fever	☐ Y ☐ N	Tonsillitis	☐ Y ☐ N
Heart Attack/Failure	☐ Y ☐ N	Tuberculosis	☐ Y ☐ N
Heart Mumur	☐ Y ☐ N	Tumors or Growths	☐ Y ☐ N
Heart Pacemaker	☐ Y ☐ N	Ulcers	☐ Y ☐ N
Heart Trouble/Dz	☐ Y ☐ N	Venereal Disease	☐ Y ☐ N
☐ Other _____		Yellow Jaundice	☐ Y ☐ N

Women: Are you

☐ Pregnant/Trying to get pregnant? ☐ Nursing?
☐ Taking oral contraceptives?

DENTAL HISTORY

Why have you come to the dentist today? _____
_____
Do you require antibiotics before dental treatment? ☐ Y ☐ N
Are you currently in pain? ☐ Y ☐ N
Date of last dental visit _____/_____/_____
Date of last dental X-rays _____/_____/_____

I am interested in the following:

☐ Cleaning	☐ Implants
☐ Wisdom Teeth Removal	☐ Cosmetic Dentistry
☐ Tooth Whitening	☐ Sedation/Anesthesia
☐ Changing out old fillings	☐ Other

I understand that the information that I have given 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.

_____
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 *Special Dental Care* 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 HIPPA 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 with the patient named herein. **Initial:** _____ **Date:** _____

Doctor's Comments: _____
_____

Medical History last reviewed with patient: Changes in Medical Hx?

Signature: _____ Date: _____ ☐ Y ☐ N

Signature: _____ Date: _____ ☐ Y ☐ N

Signature: _____ Date: _____ ☐ Y ☐ N