DECATUR DENTAL SERVICES INC. PATIENT INFORMATION

Date:_____ Social Security #_____-_____-_____

Patients Name:_____ Birth Date:_____/_____/_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Who is Responsible for your Account? Self:_____ Spouse:_____ Mother:_____ Father:_____ Other:_____

Name:_____ Birth Date:_____/_____/_____ Social Security #_____-_____-_____

Address (If different than above):_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ How Long at This Address?_____

Employer:_____ How Long:_____ Work Phone:_____

Spouse's Name:_____ Birth Date:_____/_____/_____ Social Security #_____-_____-_____

Spouse's Employer:_____ How Long?_____

**Decatur Dental requires payment In full for all services rendered at the time of each visit unless other arrangements have been made. If unpaid, your account will be turned over to a collection agency. The person responsible for this account must pay all additional charges incurred in collection your account balance.

INSURANCE

Who carries the Dental Insurance? Self_____ Spouse_____ Mother_____ Father_____ Other_____

Name:_____ Employer:_____ Social Security #_____-_____-_____

Insurance Co:_____ Group #_____ ID#_____

Secondary Insurance? Self_____ Spouse_____ Mother_____ Father_____ Other _____

Name:_____ Emplolyer:_____ Social Security #_____-_____-_____

Secondary Ins. Co: _____ Group :_____ ID#_____

EMERGENCY CONTACT

Name:_____ Phone #:_____

CREDIT REPORT

I agree to allow Decatur Dental Services, Inc. to obtain a Credit Report if needed to establish an account.

Signature:_____ Date:_____

DENTAL/MEDICAL HISTORY

Reason for today's visit:_____

How many times a day do you brush?_____ How many times a week do you floss?_____

Have you ever had a problem with any previous dental procedures Y_____ N_____

ALLERGIES

Are you allergic to any of the following: _____Latex _____Penicillin/Amoxicillin _____Tetracycline _____Aspirin _____Erythromycin _____Codeine _____Dental Anesthetics _____Food Other Allergies:_____

_____

MEDICAL HISTORY

PLEASE LIST ALL CURRENT MEDICATIONS:_____

_____

Have you ever taken BONE DENSITY MEDICATIONS: (Actonel, Aredia, Boniva, Fosamax, Prolia, Reclast)? Y_____ N_____

DO YOU NEED PRE-MEDICATION ANTIBIOTICS BEFORE YOUR DENTAL APPOINTMENT? Y_____ N_____

Do you use tobacco? Y_____ N_____ If Yes, what type?_____How much per day?_____How long?_____

For Women: Are you pregnant? Y_____ N_____ How far along_____ Are you nursing? Y_____ N_____

Are you taking Birth Control? Y_____ N_____

Have you ever had any of the following Medical Conditions?

Y	N	ALCOHOL/DRUG ABUSE	Y	N	EPILEPSY	Y	N	NERVOUS DISORDERS
Y	N	ALZHEIMER'S/DEMENTIA	Y	N	FAINTING	Y	N	OSTEOPOROSIS/BRITTLE BONES
Y	N	ANEMIA	Y	N	FREQUENT HEADACHES	Y	N	PACEMAKER/DEFIBRILLATOR
Y	N	ARTIFICIAL JOINTS/BONES	Y	N	GLAUCOMA	Y	N	PARKINSON'S
Y	N	ARTIFICIAL VALVES	Y	N	HEART ATTACK	Y	N	PSYCHIATRIC DISORDERS
Y	N	ARTHRITIS/RHEUMATISM	Y	N	HEART DISEASE	Y	N	RADIATION TREATMENT
Y	N	ASTHMA/DIFFICULTY BREATHING	Y	N	HEART MURMUR	Y	N	RHEUMATIC FEVER
Y	N	ATRIAL FIBRILLATION (A-FIB)	Y	N	HEART SURGERY	Y	N	SCARLET FEVER
Y	N	BACK PROBLEMS	Y	N	HEPATITIS ___A ___B ___C	Y	N	SEIZURES
Y	N	BLEEDING PROBLEMS	Y	N	HIGH/LOW BLOOD PRESSURE	Y	N	SHINGLES
Y	N	CANCER/TUMORS	Y	N	HIV/AIDS/ARC	Y	N	SINUS PROBLEMS
Y	N	CHEMOTHERAPY	Y	N	JAW PROBLEMS (TMJ/TMD)	Y	N	STOMACH PROBLEMS/ULCERS
Y	N	CHEST PAINS	Y	N	KIDNEY PROBLEMS	Y	N	STROKE
Y	N	CHOLESTEROL PROBLEMS	Y	N	LEUKEMIA	Y	N	THYROID DISEASE
Y	N	CONGENITAL HEART DEFECT	Y	N	LIVER PROBLEMS	Y	N	TUBERCULOSIS (TB)
Y	N	COSMETIC SURGERY	Y	N	MITRAL VALVE PROLAPSE	Y	N	VENEREAL DISEASE
Y	N	DIABETES	Y	N	NECK PAIN/SWOLLEN GLANDS			
Y	N	EMPHYSEMA/COPD						

Please list any other health conditions:_____

_____

CONSENT

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 treatment with my informed consent.

Signature:_____Date:_____

Decatur Dental Services, Inc. is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA