TOTAL DENTAL CARE

of Middle Island, P.C.

PATIENT INFORMATION (ADULT)

Date

Name

Address

City State Zip

Home Phone Cell Phone

Date of Birth Age

Social Security#

Sex: □ Male □ Female
Status: □ Single □ Married □ Widowed □ Divorced

Occupation Employer

Employer Address Phone

Email Address

Spouse's Name *Cell Phone*

Spouse's Date of Birth *Spouse's SS#*

Spouse's Occupation *Employer*

Employer's Address *Phone*

In case of an emergency, name person not living in your household:

Name Relationship

Home Phone Work Phone

Whom may we thank for referring you?

Have you seen/heard any of our advertising?
□ Newspaper □ Movie Theater □ Mailings □ Website
□ Radio If yes, what radio station ? _____

INSURANCE INFORMATION:

Dental Insurance (Primary)

Subscriber's Name

Subscriber's SS# or ID#

Group#

Dental Insurance (Secondary)

Subscriber's Name

Subscriber's SS# or ID #

Group#

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependant) have insurance coverage with _____ and assign directly to **Total Dental Care of Middle Island, P.C.** 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance claims.

Responsible Party Signature

Relationship Date

DENTAL INFORMATION:

Reason for today's visit

Former Dentist City/State

Date of last dental visit

Date of last dental x-rays

PLEASE ANSWER YES/NO TO THE FOLLOWING:

Y	N	
□	□	Bad breath
□	□	Bleeding gums
□	□	Blisters on lips/mouth
□	□	Burning sensation on tongue
□	□	Chew on one side of mouth
□	□	Cigarette, pipe/cigar smoking
□	□	Clicking or popping jaw
□	□	Dry mouth
□	□	Fingernail biting
□	□	Food collection between teeth
□	□	Grinding teeth
□	□	Gums swollen or tender
□	□	Jaw pain or tiredness
□	□	Lip or cheek biting
□	□	Loose teeth or broken fillings
□	□	Mouth breathing
□	□	Mouth pain, brushing
□	□	Orthodontic treatment
□	□	Pain around ear
□	□	Periodontal treatment
□	□	Sensitivity to cold
□	□	Sensitivity to heat
□	□	Sensitivity to sweets
□	□	Sensitivity when biting
□	□	Sores or growths in mouth

How often do you floss? _____
How often do you brush? _____
If there was a way to brighten or straighten your teeth, would you like to hear about it? □ Yes □ No

MEDICAL HISTORY: CERTAIN ILLNESSES OR DRUGS MAY MAKE IT NECESSARY TO ALTER OUR TREATMENT IN OUR ENDEAVOR TO RENDER THE BEST POSSIBLE ORAL HEALTH CARE. IT IS NECESSARY TO HAVE THE FOLLOWING INFORMATION.

Doctor's Name

Address

City State Zip

Phone

Date last physical and reason

HAVE YOU EVER OR NOW HAVE (PLEASE CHECK YES OR NO):

Y	N	
□	□	AIDS
□	□	ANEMIA
□	□	ARTHRITIS, RHEUMATISM
□	□	ARTIFICIAL HEART VALVES
□	□	ARTIFICIAL JOINTS
□	□	ASTHMA
□	□	BACK PROBLEMS
□	□	BLEEDING ABNORMALLY WITH EXTRACTIONS OR SURGERY
□	□	BLOOD DISEASE
□	□	BLADDER CONDITIONS
□	□	BLOOD TRANSFUSIONS
□	□	BIRTH DEFECTS
□	□	BRAIN INJURY
□	□	BRUISING EASILY
□	□	CANCER OR MALIGNANCIES
□	□	CEREBRAL PALSY
□	□	CHEMICAL DEPENDANCY
□	□	CHEMOTHERAPY
□	□	CHRONIC HEADACHES
□	□	CONGENITAL HEART LESIONS
□	□	CONTACT LENSES
□	□	CORTIZONE TREATMENTS
□	□	COUCH, PERSISTANT OR BLOODY
□	□	DIABETES
□	□	DRUG/ALCOHOL ABUSE
□	□	EMPHYSEMA
□	□	EPILEPSY
□	□	EYE PROBLEM
□	□	EXCESSIVE BLEEDING
□	□	FAINTING OR DIZZINESS
□	□	FREQUENT INFECTIONS
□	□	GLAUCOMA
□	□	HEADACHES
□	□	HEART MURMUR
□	□	HEART PROBLEMS
□	□	HEMOPHELIA
□	□	HEPATITIS TYPE _____
□	□	HERPES
□	□	HPV
□	□	HIGH BLOOD PRESSURE
□	□	HIV POSITIVE
□	□	KIDNEY DISEASE
□	□	LEUKEMIA
□	□	LIVER DISEASE
□	□	LOW BLOOD PRESSURE
□	□	MITRAL VALVE PROLAPSE
□	□	NERVOUS PROBLEMS
□	□	NUTRITIONAL/EATING DISORDER
□	□	ORAL ULCERS
□	□	ORTHOPEDIC PROBLEMS
□	□	PNEUMONIA
□	□	PREMATURE BIRTH
□	□	PSYCHIATRIC CARE
□	□	RADIATION TREATMENT
□	□	RESPIRATORY DISEASE
□	□	RHEUMATIC FEVER
□	□	SCARLET FEVER
□	□	SCOLIOSIS
□	□	SHORTNESS OF BREATH
□	□	SKIN RASH
□	□	SICKLE CELL ENEMIA
□	□	SINUS PROBLEMS
□	□	SORE THROAT (FREQUENT)
□	□	SPECIAL DIET
□	□	SPINA BIFIDA
□	□	SWOLLEN NECK GLANDS
□	□	SYNDROME/TYPE
□	□	TUBERCULOSIS
□	□	TUMOR OR GROWTH
□	□	ULCERS
□	□	VENEREAL DISEASE
□	□	WEIGHT LOSS (UNEXPLAINED)
□	□	OTHER

Please describe any current medical treatment including drugs, pending surgery, recent injuries, or any other information we should be aware of that has not been covered_____

_____

MEDICATIONS: (List all you are currently taking)

_____

_____

ALLERGIES:

Aspirin	□ YES □ NO
Barbiturates (sleeping pills)	□ YES □ NO
Codeine	□ YES □ NO
Iodine	□ YES □ NO
Latex	□ YES □ NO
Local Anesthetic	□ YES □ NO
Penicillin	□ YES □ NO
Sulfa	□ YES □ NO
Other (list below)	□ YES □ NO

_____

Have you had surgery in the last 5 years?
□ YES □ NO
If yes, explain _____
Where there any complications?
□ YES □ NO
If yes, explain _____
Have you ever been told you need to be pre-medicated with antibiotics for dental treatment?
□ YES □ NO

_____
Doctor's Name

_____
Address

_____
City State Zip

_____
Phone

_____
Date last physical and reason

I ACKNOWLEDGE THAT THE INFORMATION ABOVE AND ON THE OTHER SIDE IS CORRECT

_____
SIGNATURE OF PATIENT

_____
DATE

_____
WITNESS

_____
DOCTOR'S SIGNATURE

UPDATES

Has there been any changes in your health since your last dental appointment?

□YES □NO _____
PARENT/GUARDIAN DATE

_____
DOCTOR DATE

□YES □NO _____
PARENT/GUARDIAN DATE

_____
DOCTOR DATE