PLEASANT VALLEY DENTAL

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Last name:_____ First name:_____
Preferred name:_____ Birthdate:_____
Address:_____ City:_____ Postal Code:_____
Home phone:_____ Cell Phone:_____ Work Phone:_____
Employer:_____ Occupation:_____
Email Address:_____

How did you hear about our office?_____
How do you prefer to be contacted for your appointment: ☐Email ☐Phone ☐Text

Emergency Contact Name:_____ Relationship to Patient:_____
Home Phone:_____ Cell Phone:_____

INSURANCE

PRIMARY

Subscriber Name:_____ Relationship to Patient:_____
Subscriber Date of Birth:_____ Insurance Company:_____
Group Number:_____ ID Number:_____

SECONDARY

Subscriber Name:_____ Relationship to Patient:_____
Subscriber Date of Birth:_____ Insurance Company:_____
Group Number:_____ ID Number:_____

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Pleasant Valley Dental all insurance benefits, if any, otherwise payable to me for services rendered. <u>I understand I am financially responsible for all charges whether or not paid by insurance</u>. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Responsible Party Signature:_____
Date:_____ Relationship:_____

I consent to the diagnostic procedures and treatment by the dentist/dental hygienist necessary for proper dental care.

Patient (Parent/Guardian) Signature:_____
If Parent/Guardian- please print name:_____

PLEASANT VALLEY DENTAL

MEDICAL HISTORY

YES NO 1. Are you currently being treated for any medical condition or have you been treated within the past year? If so, why?_____

YES NO 2. Have you ever had a serious illness?_____

YES NO 3. Was your last medical check-up within the past year?_____

YES NO 4. Do you have any allergies? Please list:

_____

YES NO 5. Have you ever had a peculiar or adverse reaction to any medications or injections? (e.g. penicillin, local anesthetics, "dental freezing").

_____

YES NO 6. Are you taking medications at present (prescription or non-prescription)?
Please list:

_____

7. Do you have or have you ever had any of the following? Check off (√) all that apply.

☐ Any heart condition ☐ Heart attack ☐ Heart infections (endocarditis)
☐ Blood pressure problem ☐ Stroke/TIA ☐ Heart failure
☐ Chest pain/ angina ☐ Heart surgery ☐ Congenital heart problems
☐ NONE OF THE ABOVE

YES NO 8. Do you have any tendency to bruise easily or bleed for a prolonged period of time after a cut?

_____

YES NO 9. Do you take any blood thinners?_____

YES NO 10. Do you have any condition that could affect your immune system (e.g. Leukemia, HIV/AIDS, immunosuppressants)?

_____

YES NO 11. Have you ever been hospitalized for any illness or surgery?

_____

12. Do you have or have you ever had any of the following? Check off (V) all that apply.

☐ Diabetes (Type _____) ☐ Asthma ☐ Bone strengthening pills/injections (Bisphosphonates)
☐ Thyroid problems ☐ Tuberculosis ☐ Prosthetic joints
☐ Liver disease/ Hepatitis ☐ Lung disease ☐ Arthritis (Type_____)
☐ Kidney disease ☐ Steroid therapy ☐ Cancer
☐ Depression/Anxiety ☐ Stomach ulcers ☐ Seizures/ Epilepsy
☐ NONE OF THE ABOVE

YES NO 13. Are there any conditions not listed above that you have or have had? If yes, what?

_____

YES NO 14. Have you ever had injury, surgery or radiation therapy of the face or jaws? If yes, what?

_____

YES NO 15. Are there any medical conditions that run in your family (e.g. heart disease, diabetes, cancer)?

_____

YES NO 16. Do you smoke? If so, how much? _____

YES NO 17. Do you use recreational drugs? _____

18. What is: your weight: _____ your height: _____

YES NO 19. For women only, are you pregnant or breastfeeding? _____
Delivery date: _____

YES NO 20. Are you currently in good health? _____

I acknowledge that the information given above is true to the best of my knowledge. Should there be any change to my present health status in the future, I will advise Pleasant Valley Dental. I give consent for my physician to be contacted by letter, fax or telephone in order to complete details of my medical history or to discuss any necessary medical management/precautions for dental care. I hereby consent to my physician providing Pleasant Valley Dental with any information in this regard which may help ensure safe dental treatment.

Patient Name: _____

Patient Signature: _____ Date: _____

Physician's Name: _____ Physician's Phone Number: _____