PURDY FAMILY DENTISTRY

We are dedicated to providing you with an efficient, respectful and comforting clinic.
Please help us by providing this information. Thank You

Home Phone Number____________________________________ Cell Phone ________________________

Patient Name ____ Preferred Name ____________________

Address ____ Single _____ Married ______

City ____ Date of Birth ______________________

State _________ Zip ___________ Email ____ Sex M____ F_____

Employed by ____ Occupation________________________

Business Phone (if we are able to call you at work) ____

Parent/Spouse Name ___________________________________ Business Phone ____________________

In case of Emergency, contact ___________________________ at __________________ Relationship ____________

Whom may we thank for referring you? ____

INSURANCE INFORMATION

Policy Holder __________________________ DOB ____________ Relationship to Patient_______________

SSN ______________________________ Name of Employer ____

Group Number __________________ Name of Insurance Company ____

Insurance Company Address ____

Is the Policy Holder also the Responsible Party ______ If so, please skip Responsible Party Section

Do you have Secondary Coverage ___________ Policy Holder ______________________

Relationship to Patient ___________________ SSN __________________ DOB _____________________________

Name of Employer ___________________________ Name of Insurance Company ____________________________

Group Number __________ Address of Insurance Company ____

RESPONSIBLE PARTY

Name ______________________________________ Relationship to Patient _______________

Complete Street Address ____

Home Phone Number ____ Business Phone ____________________

The above Information is accurate and complete to the best of my knowledge. It is used in my treatment, billing and processing of insurance. I am responsible for any errors or omissions that I may have made in completing this form. I am also aware that Purdy Family Dentistry, in accordance with HIPAA has available to me the Notice of Privacy if I so wish to read it before signing.

Patient Signature ____ Date _________________________

OVER→

PURDY FAMILY DENTISTRY

MEDICAL HISTORY

Name: ___________________________________ Date of Birth: _____________

Name and phone number of Physician: _____________________________ Last exam: _____________

Are you now under the care of a physician? ___ If yes, explain: ______________________________

Are you taking any medications? ___ **Please List:** ____

____

Are you allergic to (**Please Circle**): ·Penicillin ·Codeine ·Local Anesthetic ·Latex ·Other: _____________

Do you have, or have you ever had (please <u>circle/check</u>):

Heart Trouble:	___	Tuberculosis or Lung disease:	___	Nervous Problems:	___
Heart Murmur:	___	Excessive or prolonged bleeding:	___	Artificial Heart Values:	___
Heart surgery, pacemaker:	___	Glaucoma:	___	Artificial Joints:	___
Rheumatic fever:	___	Hepatitis: _____ Type: ____	___	Respiratory Disease:	___
High/Low blood pressure:	H/L	Psychiatric Care:	___	Mitral Valve Prolapse:	___
Diabetes:	___	Cancer, Chemotherapy/Radiation:	___	Blood Disease:	___
Hemophilia:	___	Epilepsy, Asthma, Anemia:	___	HIV positive/ AIDS:	___
Swollen Neck Glands:	___	Prosthetic Implants:	___	Chemical Dependency:	___
Thyroid problem:	___	Stroke:	___	Tobacco Use: ____ Years	___

Have you had any other serious illness, hospitalization or accident? ___________________________________

(**Women**) Are you pregnant? ___________ Are you nursing? _______

Patient Signature: ______________________________________ Date: _________________

Staff member Signature: ______________________________ Blood pressure __________ Pulse _________

DENTAL HISTORY

Former Dentist and phone number: ____

When was your last dental cleaning? _________________ Were x-rays taken? ___

Are you aware of any dental problems? ______________ Does food chronically collect between your teeth? _____

Do your gums bleed? ___ Have you ever been told you have gum disease? ____

Are your teeth acutely sensitive to: Sweet ___ Cold ___ Heat ___ Pressure ___ None ___

How often do you brush your teeth? ___________ Floss? _________

Has any dental treatment been recommended to you that has not been completed at this time? _________________

Are you happy with the appearance of your smile? ____ Explain ____

Anything else that would be valuable for me to know? ____