



**SOUTH MOUNTAIN
FAMILY DENTISTRY**

Date _____

Name _____ Sex ___M___F Age _____ Date of Birth _____
(Last) (First) (MI)

Address _____
(Mailing Address)

City _____ State _____ Zip _____ Cell Phone: _____

Marital Status: Married _____ Widowed _____ Single _____ Minor _____ Separated _____ Divorced _____ Partnered _____

SSN: _____ EMAIL: _____

Patient Employer/School: _____ Work Phone: _____

Emergency Contact

Name _____ Relationship to Patient? _____
LAST FIRST MI

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Primary Insurance

Who is responsible for this account: _____ Relationship to Patient? _____

Home Phone _____ Cell Phone _____

Insurance Co. _____ Group# _____

Subscriber's Name: _____ Birth Date: _____

SSN: _____ Employer: _____

If the patient has additional insurance please notify someone at the front desk

****WHEN FILING INSURANCE THE SOCIAL SECURITY NUMBER & DATE OF BIRTH OF THE POLICY HOLDER ARE REQUIRED****

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Hudson Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I certify that all of this information is true and accurate including the following medical information.

Signature/Relationship: _____ Date: _____

PATIENT NAME: _____ DOB: _____

Dental History

Reason for today's visit: _____

Former Dentist _____ City/State _____

Date of last dental visit: _____ Date of last dental x-rays: _____

Health History

Physician's Name _____ Date of Last Visit: _____

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

Are you on a Pain Contract? ___ Yes ___ No If so, with which Doctor? _____

Do you use tobacco products? ___ Yes ___ No

WOMEN ONLY:

Are you pregnant? ___ Yes ___ NO Due Date _____/_____/_____
MONTH DAY YEAR

Are you nursing? ___ Yes ___ No Are you taking Birth Control? ___ Yes ___ No

Do you have a history of bacterial endocarditis? ___ Yes ___ No *If yes, when were you diagnosed? _____

Do you have history of any type of cancer? ___ Yes ___ No *If yes, what type of Cancer? _____

Are you currently taking chemotherapy or radiation treatments? ___ Yes ___ No

Have you ever taken any of the group of drugs collectively referred to as "bisphosphonates"? These include but are not limited to: Fosamax, Zometa, Aredia, Actonel, and Skelid. ___ Yes ___ No

Have you or are you currently taking any blood thinners? ___ Yes ___ No *If yes, what medication? _____

Do you have any stents, valves, or joint replacements? ___ Yes ___ No *If yes, when? _____

Do you have history of any heart attacks or strokes? ___ Yes ___ No *If yes, when? _____

PLEASE LIST ANY MEDICATIONS YOU ARE TAKING:

PLEASE LIST ANY KNOWN ALLERGIES:

PATIENT NAME: _____ DOB: _____

Pharmacy Name: _____ Phone: _____

Address _____ City _____ State _____ ZIP _____

Place a mark (X) on "Yes" or "No" to indicate if you have or have had any of the following:

- | | | | | | |
|---------------------------|-------------|-----------------------|-------------|-------------------------|-------------|
| AIDS/HIV | ___Yes___No | Epilepsy | ___Yes___No | Rheumatic Fever | ___Yes___No |
| Anemia | ___Yes___No | Fainting/Dizziness | ___Yes___No | Scarlet Fever | ___Yes___No |
| Arthritis, Rheumatism | ___Yes___No | Glaucoma | ___Yes___No | Short of Breath | ___Yes___No |
| Artificial Heart Valve | ___Yes___No | Headaches | ___Yes___No | Sinus trouble | ___Yes___No |
| Artificial Joints | ___Yes___No | Heart Murmur | ___Yes___No | Skin Rash | ___Yes___No |
| Asthma | ___Yes___No | Heart Problems | ___Yes___No | Special Diet | ___Yes___No |
| Bleeding abnormally, with | | Hepatitis Type___ | ___Yes___No | Stroke | ___Yes___No |
| Extractions or surgery | ___Yes___No | Herpes | ___Yes___No | Swollen Limbs | ___Yes___No |
| Blood Disease | ___Yes___No | High Blood Pressure | ___Yes___No | Swollen Glands | ___Yes___No |
| Cancer | ___Yes___No | Jaundice | ___Yes___No | Thyroid Problem | ___Yes___No |
| Chemical dependency | ___Yes___No | Kidney Disease | ___Yes___No | Tuberculosis | ___Yes___No |
| Chemotherapy | ___Yes___No | Liver Disease | ___Yes___No | Tumor or growth on head | |
| Circulatory Problems | ___Yes___No | Low Blood Pressure | ___Yes___No | or Neck | ___Yes___No |
| Congenital Hlth Lesions | ___Yes___No | Mitral Valve Prolapse | ___Yes___No | Ulcer | ___Yes___No |
| Cortisone Treatments | ___Yes___No | Nervous Problems | ___Yes___No | Weight Loss | ___Yes___No |
| Cough, persistent | ___Yes___No | Pacemaker | ___Yes___No | OTHER: _____ | |
| Diabetes | ___Yes___No | Psychiatric Care | ___Yes___No | _____ | |
| Emphysema | ___Yes___No | Radiation Treatment | ___Yes___No | _____ | |

Additional Notes:

