Shandon Family Dentistry

WELCOME FORMS (Please Print)

Section I: Patient Information Date_____

Name:_____ I Prefer to be called: _____
Address:_____City:_____State:_____Zip_____
Phone (_____)_____ Work Phone (_____) _____ Gender: ☐ Male ☐ Female
Date of Birth:_____ Social Security Number:_____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If Student, Name of School_____ City/State_____ ☐ FT ☐ PT
Spouse or Parent's Name:_____ Employer_____ Work Phone_____
Whom may we thank for referring you? _____
Person to contact in case of emergency_____ Phone_____

Section II Responsible Party

Relationship to Patient: ☐ Self (If self, proceed to Section III) ☐ Spouse ☐ Parent ☐ Other
Name:_____ _____ _____
Address:_____
City:_____ State:_____ Zip:_____ Phone: (____)_____
Employer_____ Work Phone (____)_____ SSN#_____

Section III Insurance Information

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

---------- DO YOU HAVE ANY SECONDARY INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer: _____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Affordable Dentistry PA 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 practice to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.
Responsible Party Signature: _____ Date: _____

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Section IV — Medical History

Physician's Name and Phone Number: _____
Emergency Contact: _____(name) _____ (phone)_____(relationship)
Have you ever undergone a surgical procedure? (circle) YES NO If so, please list:_____
Have you had steroid/cortisone therapy within the past two years? (circle) YES NO
Have you ever taken oral or intravenous bisphosphonates, e.g., Fosamax, Actonel, Boniva, Zometa, or Aredia? circle YES NO
Have you had a total joint replacement? (circle) YES NO If so, when was that? _____

DO YOU HAVE A HISTORY OF THE FOLLOWING CONDITIONS? ***BE SURE TO MARK EITHER A YES OR NO FOR EACH***

	Yes	No		Yes	No		Yes	No
Rheumatic Fever			Diabetes			Aspirin/Anticoagulant Therapy		
Heart Murmur			Lung Disease			Venereal Disease		
Mitral Valve Prolapse			Breathing Problems			HIV Positive/Aids		
Heart Surgery			Tuberculosis			Blood Transfusion		
High Blood Pressure			Asthma			Excessive Bleeding		
Low Blood Pressure			Allergies			Hepatitis (type ___)		
Pace Maker			Anemia			Liver Disease		
Stroke			Sinus Problems			Kidney Disease		
Cancer (type _____)			Arthritis			Dialysis		
Radiation Treatment			Thyroid Disease			Psychiatric Treatment		
Chemotherapy			Epilepsy or Seizures			Mouth Sores/Growths		
Use of Tobacco			Fainting			Teeth Grinding/Clenching		
Drug Addiction			Ulcers or Stomach Problems			TMJ Pain		
Alcoholism			Latex Allergy			Other Disease or Illness:		
Any type of Implant			Artificial Heart Valve					
Any type of Transplant			Infective Endocarditis					
Any Artificial Hip, Knee, or Joint			Congenital Heart Condition					

For Women:	*Yes*	*No*		*Yes*	*No*
Is there a possibility of pregnancy?			***Are you nursing?***		
Estimated Delivery Date / /			***Are you taking any birth control medications?***		

Note: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistant regarding additional methods of contraception.

Please list any medications you are currently taking:_____
_____
Please list any medications you are allergic to:_____

I certify that I have read and understand the above medical history questions and acknowledge that these questions have been answered to the best of my knowledge.

Patient's (or Legal Guardian's) Signature _____ Date _____

Staff Medical History Review Signature _____ Date _____

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Section V **Communication**

At Shandon Family Dentistry, we provide convenient alternative methods for delivering our courtesy appointment reminders to save you time.

Cell Phone Number to Receive Text Appointment Reminders: _____

Email address to Receive Email Appointment Reminders: _____

Mailing address to Receive Hygiene Appointment Reminders: _____

☐ (check here if it is the same address from Section I)

Section VI **Dental History**

How may we help you today: _____

Are you currently in any dental pain? (circle) YES NO

If so, please describe:_____

Your current dental health is: (circle) Good Fair Poor

How many times do you: _____ brush/day _____ floss/week

Do your gums ever bleed? (circle) YES NO

Have you ever had periodontal disease? (circle) YES NO

Has a physician ever advised you to have antibiotic premedication before dental treatment? (circle) YES NO

Are you teeth sensitive to hot, cold, or anything else? (circle) YES NO

Are you happy with your smile? (circle) YES NO

If not, what would you change about it? _____

Are you interested in any of our teeth whitening procedures? (circle) YES NO

When was your last dental cleaning? _____

How may we better accommodate you during your dental visit? _____

Upon completion of these forms, please return them to our patient coordinator. Thank you and we welcome you to Shandon Family Dentistry.