SOUTHERN DENTAL — TUSCANO DENTAL

Welcome to our office. Please complete fully and print legibly

.

PATIENT INFORMATION

PATIENT'S NAME ______________________________ SS# ______________

BIRTHDATE ______________ AGE ________ SEX ________ MARITAL STATUS ______________

ADDRESS ______________________________ CITY ____________ STATE ______ ZIP __________

EMAIL ______________________________ HOME # ______________ CELL # ______________

WHICH IS THE BEST WAY TO CONTACT YOU ? ______________________________

PLACE OF EMPLOYMENT ______________________________ WORK # ______________

PERSON TO NOTIFY IN CASE OF EN EMERGENCY ______________________ PHONE # ______________

STUDENT: FULL TIME / PART TIME SCHOOL ______________________________

RESPONSIBLE PARTY'S INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT ______________________________

RELATIONSHIP TO PATIENT ______________________ HOME # ____________ WORK # ____________

MAILING ADDRESS ______________________________ CITY ____________ STATE ______ ZIP __________

SS # ______________________ EMPLOYLER ______________________________

PRIMARY DENTAL INSURANCE

INSURED'S NAME ______________________________

ID# ______________ GROUP # ______________

EMPLOYER ______________________________

PLAN NAME ______________________________

SECONDARY DENTAL INSURANCE

INSURED'S NAME ______________________________

ID # ______________ GROUP# ______________

EMPLOYER ______________________________

PLAN NAME ______________________________

HOW DID YOU HEAR ABOUT OUR OFFICE ? CURRENT PATIENT ? (NAME ______________________________)

INSURANCE CO PHONE BOOK SAW BLDG/SIGN EMPLOPYER WEBSITE

WHY ARE YOU HERE TODAY? ______________________________

Check up, toothache, consultation ect…..

This is to certify that I, the undersigned, consent to the performing of whatever dental services and/or surgical procedures may be decided upon to be necessary or advisable, and to the use of local anesthetic as may be deemed advisable by the dentist. I hereby authorize my dentist to release any and all medical and dental information necessary or to the above named insurance carrier for purpose of claims administration, utilization review and financial audit. This authorization remains valid and effective from the date of signing until evoke in writing.

I hereby authorize my insurance carrier to pay directly to **Southern Dental - Tuscano Dental**, the dental benefits otherwise payable to me.

______________________ __________ ______________________ __________

PATIENT SIGNATURE DATE RESPONSIBLE PARTY DATE

Southern Dental **Tuscano Dental**

PATIENT HEALTH HISTORY
MEDICAL HISTORY

Are you in good health ? Yes / No Date of last physical exam:____________
Name of family physician:____________ Phone # ____________
Are you now under the care of a physician ? ____________ Y / N
Have you ever had any serious illness or operation ? ____________ Y / N
If so, what illness or operation ?____________
Are you taking any medication ? Yes No or any recreational drugs (marijuana, cocaine, ect…) Y / N
If so, what ? ____________ Dosage ? ____________
Have you ever been pre-medicated with antibiotics BEFORE dental treatment ? ____________ Y / N
Are you ALLERGIC OR SENSITIVE to : Penicillin Tetracycline Aspirin Codeine Y / N
OTHER MEDICATION ALLERGIES ____________

Do you have or have you had any of the following: Please circle Yes (Y) or No (N)

Anemia	Y / N	Asthma	Y / N	Cerebral Palsy	Y / N	Heart Attack	Y / N
Diabetes	Y / N	Emphysema	Y / N	Nervous Disorder	Y / N	Faint Spell	Y / N
Tonsillitis	Y / N	Cortisone Meds	Y / N	Chemotherapy	Y / N	Heart Murmur	Y / N
Cold sores	Y / N	Excessive Bleeding	Y / N	Radiation Treatment	Y / N	Head Injury	Y / N
Hemophilia	Y / N	High Blood Pressure	Y / N	Heart Failure	Y / N	Rheumatism	Y / N
TMJ	Y / N	Hepatitis	Y / N	Mitral Valve Prolapse	Y / N	Liver Disease	Y / N
Respiratory Disease	Y / N	HIV / AIDS	Y / N	Rheumatic Fever	Y / N	Scarlet Fever	Y / N
Sickle Cell	Y / N	Thyroid Disease	Y / N	Sinus Trouble	Y / N	Herpes	Y / N
Joint Replacement	Y / N	Blood Disease	Y / N	Epilepsy/ Seizures	Y / N	Tuberculosis (TB)	Y / N
Drug Addiction	Y / N	Psychiatric Treatment	Y / N	Hearing Impaired	Y / N	Kidney Disease	Y / N
Latex Allergy	Y / N	Artificial Prosthesis	Y / N	Angina Pectoris	Y / N	Difficult Swallowing	Y / N

Do you have any disease, condition or problem not listed that you think we should know about ?____________ Y / N
If so, what ? ____________

Do you smoke or use tobacco products ? Yes / No If Yes, how much ?____________per day. .
Women—Is there a possibility that you are may be pregnant ? ____________ Y / N
Women—Do you take birth control pills ? ____________ Y / N

DENTAL HISTORY

Previous Dentist ____________City____________State____________
Have you been having any specific problem ? Yes / No. Please Explain____________
Is any current dental problem the result of an accident ? Yes / No Please Explain ____________
Do you have, or have you had any of the following (please circle):
Bad breath Bleeding gums Sensitive teeth Jaws lock / pop
Have you ever had any of the following:
Facial Injury Oral surgery Periodontal Disease Jaw Injury Orthodontics TMJ Treatment
Please explain: ____________
Have you had any unfavorable reaction from a local anesthetic ? ____________ Y / N
How long since your last dental X-rays ?____________
How long since your last dental treatment ? ____________

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications Change, will inform the doctor at my next appointment.

Signature:____________ Date: ____________

Dentist Signature: ____________ Date: ____________

Office use only:	Reviewed by	Date	Reviewed by	Date	Reviewed by	Date
	______	______	______	______	______	______
	______	______	______	______	______	______
	______	______	______	______	______	______