Welcome to Elwood Family Dental Care

Please help us provide you with the best dental care possible by completing the following confidential patient information sheet. If you need assistance or if you have any questions, please ask!

PATIENT INFORMATION

Today's Date_____
SS#_____

Name_____ M or F Birthdate_____
Address_____ City_____ State_____ Zip_____
Home Phone_____ Cell Phone_____ Minor - Y or N
Single_____ Married_____ Divorced_____ Widowed_____ Separated_____
If student, name of college_____ City_____ State_____
Patient or Parent/Guardian's Employer_____ Work Phone _____
Work Address_____ City_____ State_____ Zip_____
Spouse or Parent/Guardian's Name_____ Employer_____ Work Phone_____
Emergency Contact_____ Phone _____

We are now able to confirm appointments by email or text. How may we contact you?
____Cell phone ____Home phone ____Text ____Email (please provide) _____

Whom may we thank for referring you?_____

RESPONSIBLE PARTY (If same as patient, skip to the next section)

Person responsible for this account_____ Relationship to patient_____
Address_____ City_____ State_____ Zip_____
Home phone_____ Cell Phone_____ SS#_____ Birthdate_____
Employer_____ Work Phone_____
Is this person currently a patient at our office? _____

DENTAL INSURANCE INFORMATION (If you have insurance card, we can make a copy, and you can skip this section)

PRIMARY INSURANCE
Name of Insured_____ Birthdate_____ Relationship to patient_____
SS#_____ Name of Employer_____
Insurance Company_____ Group#_____ Policy ID#_____

SECONDARY INSURANCE
Name of Insured_____ Birthdate_____ Relationship to patient_____
SS#_____ Name of Employer_____
Insurance Company_____ Group#_____ Policy ID#_____

DENTAL HISTORY

Where was your last dental visit?_____ Date_____
Have you ever been told you have periodontal disease?_____
If you could change something about your teeth, what would it be?_____

PATIENT MEDICAL HISTORY (Continued on the back page)

Physician_____ Office Phone_____ Date of Last Exam_____
Pharmacy_____

please continue on the other side

Are you currently under medical treatment? _____ (if yes, please explain)_____

Have you had any surgeries or serious illnesses in the last 5 years? (if yes, please explain)_____

Please list any medications (prescription and non-prescription) that you are currently taking_____

*Do you take (or have you ever taken) bisphosphonates (Fosamax, Boniva, etc.) for your bones?_____
If yes, which one? **Fosamax** **Boniva** **Reclast/Zometa** **Prolia/Xgeva** **Other**
*Do you take any blood thinners? If so, what is the name of it?_____
*Do you have a persistent unexplained cough or throat clearing lasting more than 3 weeks?_____

Are you allergic to any of the following?

Y or N Local Anesthetic
Y or N Penicillin/Amoxicillin
Y or N Sulfa Drugs
Y or N Other antibiotics_____
Y or N Barbiturates
Y or N Sedatives
Y or N Latex
Y or N Aspirin
Y or N Iodine
Y or N Metals (Nickel, Mercury, Jewelry, etc.)
Y or N Other (please list)_____

Do you use tobacco?.....Y or N
Do you drink alcohol?.....Y or N
If so, what type?_____
Do you use controlled substances?.....Y or N
Have you ever taken Fen-Phen/Redux?.....Y or N

Women:
Are you pregnant or think you might be? _____

Due Date_____

Do you have or have you had any of the following?

Y or N High Blood Pressure
Y or N Heart Attack
Y or N Heart Disease or other heart problems
Y or N Mitral Valve Prolapse
Y or N Rheumatic Fever
Y or N Heart Murmur
Y or N Cardiac Pacemaker
Y or N Stroke
Y or N Seizures/Epilepsy
Y or N Kidney Disease
Y or N Respiratory Problems
Y or N Thyroid Problem
Y or N Anemia
Y or N Hepatitis
Y or N Liver Disease
Y or N Radiation Therapy
Y or N Joint Replacement - Date_____
Y or N Other_____

Y or N Emphysema
Y or N Asthma
Y or N Fainting
Y or N Tuberculosis
Y or N Cancer
Y or N AIDS/HIV
Y or N Diabetes
Y or N Arthritis

AUTHORIZATION AND RELEASE

I certify that I have read, understand and completed the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize Elwood Family Dental Care to release any information, including the diagnosis and treatment of me or my child, to third party payers and/or other health practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services, and I am responsible for the remaining balance. I agree to be responsible for payment of all services rendered on my or my dependent's behalf. I understand that payment is due on the date of service.

I give permission for my dental treatment (scheduling, insurance information, and billing) to be shared with:
(spouse, child, caretaker, etc.)_____

Signature of patient or parent/guardian_____Date_____