



Medical Alert For Office Use

Thank you for visiting our practice. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name _____
LAST FIRST MIDDLE INITIAL NICKNAME

Address _____
STREET

CITY STATE ZIP

Employer _____

Drivers License _____

Birth date _____

Height _____ Weight _____

Phone: Home () _____

Social Security # _____

Work () _____

May we contact you at work? Yes No

Mobile () _____

Male Female

Emergency: Name _____

Phone () _____

E-mail _____

Would you like to receive confirmations via text or e-mail?
 If yes, which would you prefer? _____

Insurance

Primary Dental Carrier

Subscriber Name _____

SSN # _____ DOB _____

Employer _____

Insurance Co. _____

Insurance Co. Phone # _____

Group # _____

Relation to patient _____

Secondary Dental Carrier

Subscriber Name _____

SSN# _____ DOB _____

Employer _____

Insurance Co. _____

Insurance Co. Phone # _____

Group # _____

Relation to patient _____

Insurance Authorization Statement (Sign & Date)

I hereby authorize assignment of insurance benefits to be made directly to Fallin and Fallin Family Dentistry for benefits otherwise payable to me. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature _____ Date _____

If Patient is Under 18

Responsible Party _____ Relation to Patient _____

Address _____
STREET

CITY STATE ZIP

Telephone Home () _____ Work () _____ Mobile () _____

Other Information

How did you hear about us? _____

What was the reason for today's visit? _____

Do you love your smile? _____

Is there anything you would like to change? _____

Why did you leave your last dentist? _____

What did you like most about your last dentist? _____

Are you anxious or nervous about receiving dental care? _____

How important is your dental health to you? (circle one) very important somewhat important not very important

Medical History and Information

Conditions

- | | |
|--------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Heart Surgery |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Pace Maker |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Sexually Transmitted |
| <input type="checkbox"/> Facial Surgery | <input type="checkbox"/> Disease |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> HIV+ Aids | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Tuberculosis |
| | <input type="checkbox"/> Ulcers |

Allergies

- Aspirin
- Codeine
- Dental Anesthetics
- Erythromycin
- Latex
- Metals
- Penicillin
- Sulfa
- Tetracycline
- No Known Allergies _____

Other _____

Y N

- Do you Smoke
or use Tobacco?

If Female

Y N

- Are you taking Birth
control pills?
- Are you pregnant?
If yes, # of weeks _____
- Are you Nursing?

Please list any medications
you are currently taking _____

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition. Payment for all treatment and services rendered are my responsibility.

I understand that payment is required in full at the time of service unless prior payment arrangements have been made. I hereby authorize this office to obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options.

PATIENTS SIGNATURE

DATE

If patient is a child or requires a guardian:

PARENT/GUARDIAN SIGNATURE

DATE

