FALLIN & FALLIN
FAMILY DENTISTRY

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?________________ How long has it been since your last cleaning?__________________________

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

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

____________________ ____________

PATIENTS SIGNATURE DATE

If patient is a child or requires a guardian:

____________________ ____________

PARENT/GUARDIAN SIGNATURE DATE