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 _____

Insurance

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

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