PARRISH FAMILY DENTISTRY

Today's date_____

What would you like us to call you? _____

Full Legal Name _____ **Birth Date** _____

Address_____ City _____State _____ Zip _____

Social Security # _____ Email: _____

Home # _____ Cell #_____ Work # _____

Preferred Method of contact: ____Home ____Cell ____Email

Person to contact in case of emergency _____ Phone #_____

Person responsible for this account (if not you) _____

Name of Primary Care Physician _____Phone # _____

Do any of the following conditions apply to you? If yes, you will need to take antibiotics 1 hour prior to <u>ALL</u> invasive dental procedures. (Check if Applies)

_____ Heart Surgery in the last 6 months

_____ A completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention, during the first six (6) months after the procedure

_____ Any repaired congenital heart defect with residual defect at the site or adjacent to the site of a prosthetic patch or a prosthetic device

_____ Artificial heart valves

_____ History of Endocarditis

_____ A cardiac transplant that developed a heart valve problem

_____ The following congenital (present from birth) heart condition: unrepaired or incompletely repaired cyanotic congenital heart disease, including those with palliative shunts & conduits.

_____ Total joint replacement in the last 2 years.

_____

Signature of Patient (Guardian)

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INSURANCE INFORMATION

Insurance name _____
Policyholder's Name _____ Policyholder's Birth Date_____
Policyholder's Social Security # _____
Policyholder's Employer _____
Member ID # or Subscriber ID # _____

FINANCIAL POLICY

Parrish Family Dentistry is committed to providing you with the best possible care. We will do what we can to help you receive your maximum allowable benefits.

We will gladly discuss your proposed treatment and answer any questions related to your insurance. However, some things you need to remember are:

1. Your insurance contract is between YOU, YOUR EMPLOYER and the INSURANCE COMPANY. We are **NOT** a party to that contract.
2. Filing insurance claims is a COURTESY we extend to our patients.
3. Not all services are covered benefits!
4. Any charges not paid by insurance is **YOUR RESPONSIBILITY** from the date the services are rendered.
5. You will most likely have a Co-pay!

***CO-PAYS ARE DUE AT THE TIME SERVICES ARE RENDERED. ***

Please let us know if you have questions. We are here to help!

_____ _____

Signature of Patient (Guardian) **Date**

MEDICAL HISTORY

CHECK ALL THAT APPLY:

□ High Blood Pressure

□ Are you currently taking any **BLOOD THINNERS**? (such as Aspirin, Plavix, Coumadin or Xarelto)

□ Have you ever taken **BONE DENSITY** drugs? (Such as but not limited to Boniva, Zometa, Fosamax)

□ Have you ever had radiation treatment in the **head/neck** area?

□ Are you **PREGNANT/NURSING**?

□ History of **FAINTING/SEIZURES**? Last episode_____

□ Bleeding problems?

□ Heart trouble/Pacemaker/AFIB/defibrillator/ or stent?

□ Neurological Disease? (i.e. MS, Parkinson's, Alzheimer's, etc.)

□ Immunological disease? (i.e. HIV, Hepatitis, Lupus, AIDS, etc.)

□ Diabetes? Controlled? ___yes or ___no

□ Other Medical issue(s) not listed?

_____

_____

ARE YOU <u>ALLERGIC</u> TO:

_____ Latex

_____ Metals

_____ Medications

which one (s): _____

What are your dental concerns? _____

_____ **Signature of Patient (Guardian)**

Date

Continue on Next Page

Please list CURRENT MEDICATIONS

Medication Name:	Dosage:	Why do you take this?

_____ _____

Signature of Patient (Guardian) **Date**