



# Par-La-Ville Dental

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## NEW ADULT PATIENT FORM

### About You

First Middle Last

Name \_\_\_\_\_

What you prefer to be called \_\_\_\_\_

Age \_\_\_\_\_ Male  Female  Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Home phone \_\_\_\_\_

Work phone \_\_\_\_\_

Cell phone \_\_\_\_\_

Email \_\_\_\_\_

Status:  Single  Married  Divorced  Separated  Widowed

Referred to our office by \_\_\_\_\_

#### IN CASE OF EMERGENCY

Contact name \_\_\_\_\_

Contact phone \_\_\_\_\_

Relationship \_\_\_\_\_

Cell phone \_\_\_\_\_

Who is your Medical Doctor? \_\_\_\_\_

Doctor's Phone \_\_\_\_\_

### Insurance Information

Primary Dental Insurance Co: \_\_\_\_\_

Employer: \_\_\_\_\_

Certificate #: \_\_\_\_\_

Group Policy: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Secondary Dental Insurance Co: \_\_\_\_\_

Employer: \_\_\_\_\_

Certificate #: \_\_\_\_\_

Group Policy: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Financial Information

#### Person responsible for payment:

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone #: \_\_\_\_\_

Credit card number: \_\_\_\_\_

Expiry date: \_\_\_\_\_

- Payment is expected at time of treatment.
- All emergency patients (being seen for the first time) are required to pay in full at time of treatment.
- Patients with insurance must pay their estimated portion, including deductible, at the time of service. It is the patients responsibility to see that the insurance company makes prompt payment. Any insurance balance over 60 days is due and payable by the patient.

If my account requires servicing by a collection agency or by an attorney, I understand that I will be liable for collection fees, attorney fees, and applicable court costs, in addition to my outstanding balance.  
I hereby authorize payment directly to Par-La-Ville Dental, the group insurance benefits otherwise payable to me and authorize release of information regarding treatment to the insurance company. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

\_\_\_\_\_  
**SIGNED (Guarantor)**

# Medical History

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Date of last visit: \_\_\_\_/\_\_\_\_/\_\_\_\_

Your current physical health is:  Good  Fair  Poor

Are you currently under the care of a physician?  Yes  No

Please explain: \_\_\_\_\_

Do you smoke or use tobacco in any other form?  Yes  No

Vape/e-cigarettes  Yes  No

Are you allergic to any of the following or had reaction to:

Y N Aspirin	Y N Erythromycin	Y N Penicillin
Y N Barbiturates	Y N Food	Y N Sedatives
Y N Codeine	Y N Jewelry / Metals	Y N Sulfa Drugs
Y N Dental Anesthetics	Y N Latex	Y N Tetracycline
	Y N NSAIDS	Y N Other

Please list additional drugs/materials that cause allergic reactions:  
\_\_\_\_\_

Are you taking any of the following?

Y N Acetaminophen	Y N Nitroglycerin
Y N Antibiotics	Y N Recreational Drugs
Y N Antihistamines	Y N Steroids/Cortisone
Y N Aspirin	Y N Thyroid Medicine
Y N Blood Thinners	Y N Tranquilizers
Y N Blood Pressure Medication	Y N Have you ever taken Phen-Fen? Also known as Redux or Pondimin.
Y N Cold Remedies	
Y N Digitalis/Heart Medication	
Y N Insulin/Diabetes Drugs	

Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above?  Yes  No If yes, please list each one: \_\_\_\_\_

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Hepatitis
Y N Alcohol Abuse	Y N Herpes
Y N Anemia	Y N High Blood Pressure
Y N Arthritis	Y N HIV+/AIDS
Y N Artificial Bones/Joints	Y N Hospitalized for Any Reason
Y N Artificial Valves	Y N Kidney Problems
Y N Asthma	Y N Liver Disease
Y N Blood Transfusion	Y N Low Blood Pressure
Y N Cancer	Y N Lupus
Y N Chemotherapy	Y N Mitral Valve Prolapse
Y N Chicken Pox	Y N Pacemaker
Y N Colitis	Y N Persistent Cough
Y N Congenital Heart Defect	Y N Psychiatric Problems
Y N Diabetes	Y N Radiation Treatment
Y N Difficulty Breathing	Y N Rheumatic Fever
Y N Drug Abuse	Y N Scarlet Fever
Y N Emphysema	Y N Seizures
Y N Epilepsy	Y N Shingles
Y N Fainting Spells	Y N Sickle Cell Disease
Y N Fever Blisters	Y N Sinus Problems
Y N Glaucoma	Y N Steroid Therapy
Y N Hay Fever	Y N Stroke
Y N Headaches	Y N Thyroid Problems
Y N Hearing Issues	Y N Tonsillitis
Y N Heart Attack	Y N Tuberculosis (TB)
Y N Heart Murmur	Y N Ulcers
Y N Heart Surgery	Y N Venereal Disease
Y N Hemophilia	

Please list any serious medical condition(s) that you have experienced:

\_\_\_\_\_  
\_\_\_\_\_

For Women: Are you taking birth control pills?  Yes  No

Are you pregnant?  Unsure  Yes  No

Week #: \_\_\_\_\_ Are you nursing?  Yes  No

# Dental Information

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Reason for today's visit:  Exam  Emergency  Consultation

Are you in pain?  No  Yes How Long? \_\_\_\_\_

Please indicate  any of the following problems:

- Discomfort, clicking or popping in jaw  Lost/Broken Filling(s)
- Stained teeth  Red, swollen or bleeding gums  Teeth grinding
- Locking Jaw  Sensitive tooth, teeth or gums  Ringing in Ears
- Bad breath  Blisters/Sores in or around the mouth
- Broken/Chipped tooth
- Other: \_\_\_\_\_

Do you require pre-medication?  Yes  No  Don't know

Last Dental exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last Dental X-rays: \_\_\_\_/\_\_\_\_/\_\_\_\_

Times a day you brush? \_\_\_\_\_ Times a week you floss? \_\_\_\_\_

What type of tooth brush bristles do you use?

Soft  Medium  Hard

How would you rate your smile?

(Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

I give my consent to needed dental services, local anesthetic, nitrous oxide analgesia (laughing gas) and use of proper and acceptable methods to complete same. I understand that I will be informed of any treatment (other than routine cleanings, fluoride treatments, x-rays and examinations) before that treatment is performed.

SIGNED \_\_\_\_\_

DATE \_\_\_\_\_