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 _____

Insurance Information

Primary 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:

Y N Antibiotics	Y N Food	Y N Sulfa Drugs
Y N Aspirin	Y N Latex	Y N Tetracycline
Y N Barbiturates	Y N NSAIDS	Y N Other
Y N Codeine	Y N Penicillian	
Y N Erythromycin	Y N Sedatives	

Are you allergic to any other drugs not listed above?

_____

_____

Are you taking any of the following?

Y N Antibiotics	Y N Insulin/Diabetes Drugs
Y N Antihistamines	Y N Nitroglycerin
Y N Aspirin	Y N Recreational Drugs
Y N Blood Thinners	Y N Steroids/Cortisone
Y N Blood Pressure Medication	Y N Thyroid Medicine
Y N Digitalis/Heart Medication	Y N Tranquilizers

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 Anemia	Y N Heart Disease
Y N Arthritis	Y N Hemophilia
Y N Artificial Bones/Joints	Y N Hepatitis
Y N Artificial Valves	Y N High Blood Pressure
Y N Asthma	Y N HIV+/AIDS
Y N Autism/Asperger's	Y N Hyperactivity/ADD/ADHD
Y N Cancer	Y N Kidney Problems
Y N Chemotherapy	Y N Liver Disease
Y N Colitis	Y N Lupus
Y N Crohns Disease	Y N Psychiatric Problems
Y N Congenital Heart Defect	Y N Radiation Treatment
Y N Diabetes	Y N Rheumatic Fever
Y N Difficulty Breathing	Y N Scarlet Fever
Y N Drug Abuse	Y N Seizures
Y N Emphysema	Y N Shingles
Y N Epilepsy	Y N Sickle Cell Disease
Y N Fainting Spells	Y N Sinus Problems
Y N Fever Blisters	Y N Steroid Therapy
Y N Glaucoma	Y N Stroke
Y N Hay Fever	Y N Thyroid Problems
Y N Headaches	Y N Tonsillitis
Y N Hearing Issues	Y N Tuberculosis (TB)

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

- 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**

❑ **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**