Special Need Dental

SpecialNeedDental.com

Special Need Dental Office: ______________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Last Name: ______________ First: ______________ Title: ______ Middle: ___ Preferred Name: ______________

Home Address: ____

Home Phone: ______________________ Work Phone: ______________________

Driver's License #: ______________________ SSN: ______________________

Employer Name & Address: ____

How did you hear about us? ____

Sex:

Y	N	PLEASE ANSWER THE FOLLOWING:
		Do you smoke or use tobacco?
		WOMEN:
		Are you taking birth control pills?
		Are you pregnant?
		Are you nursing?

If pregnant, how many weeks? ______________________

Height: ______________ Weight: ______________

Y	N	Allergies:
		Aspirin
		Codeine
		Dental Anesthetics
		Erythromycin
		Jewelry
		Latex
		Metals
		Penicillin
		Tetracycline
Other:		

Y	N	Condition:	Y	N	Condition:
		Abnormal Bleeding			Heart Surgery
		Alcohol Abuse			Hemophilia
		Allergies			Hepatitis A
		Anemia			Hepatitis B
		Angina Pectoris			High Blood Pressure
		Arthritis			HIV+ AIDS
		Artificial Heart Valve			Kidney Problems
		Artificial Joints (Knee, Hip, etc.)			Liver Disease
		Asthma			Low Blood Pressure
		Blood transfusion			Mitral Valve Prolapse
		Cancer-Chemotherapy			Pace maker
		Colitis			Pneumocystis
		Congenital Heart Defect			Psychiatric Problems
		Cosmetic Surgery			Radiation Therapy
		Diabetes			Rheumatic Fever
		Difficulty Breathing			Seizures
		Drug Abuse			Shingles
		Emphysema			Sickle Cell Disease
		Epilepsy			Sinus Problems
		Fainting Spells			Stroke
		Fever Blisters			Thyroid Problems
		Frequent Headaches			Tuberculosis
		Glaucoma			Ulcers
		Hay Fever			Venereal Disease
		Heart Attack			Yellow Jaundice
Any other condition not listed:					

Have you had any major surgeries? ____

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Medications:

Primary Insurance Information:

Subscriber Name & Address: ______________________________

Relation to Patient: ______________ ID#: ______________ DOB: ______________

Insurance Company Name & Address: ______________________________

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Insurance Phone #: ______________ Group #: ______________ Employer: ______________

Secondary Insurance Information:

Subscriber Name & Address: ______________________________

Relation to Patient: ______________ ID#: ______________ DOB: ______________

Insurance Company Name & Address: ______________________________

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Insurance Phone #: ______________ Group #: ______________ Employer: ______________

Responsible Party for the Patient: ______________________________

Signature: ______________________________

Any additional information you feel our staff should know in order to provide the best care possible:

Consent:

The undersigned hereby authorizes the Doctor to perform all the necessary diagnostic procedures deemed appropriate to make a thorough diagnosis of the patients' dental or oral-facial needs including but not limited to x-rays, study models, photographs, medications, and the use of local anesthetic agents.

Signature: ______________________________