Patient's Full Name ______________________ Today's Date ______________

Home Address ______________________ City ______________________

State __________ Zip __________ Home PH ______________ Cellular ______________ Work ______________

Marital Status ______________ Birthdate ______________ SSN ______________

Email Address: ______________________________
*(we will confirm appointments by email if listed above)*

FT College Student? ☐ Yes ☐ No Name Of College/University ______________________

Your Employer ______________________ Occupation ______________________

Name Of Spouse/Partner ______________________ Employed By ______________________

Person Responsible For Account ______________________ SSN ______________ DOB ______________
*(If different than above)*

Responsible Person's Address ______________________ City ______________ State ______ Zip ______

Responsible Person's Home Phone ______________ Work ______________ Cellular ______________

Dental Insurance Company ______________________ Group Number ______________________

Policyholder's Full Name ______________________ SSN/ID ______________________

Dental Insurance Is Through What Employer ______________________ Policyholder's DOB ______________

In Case Of Emergency Please Contact ______________________ Phone ______________

Physician's Name ______________________ Phone Number ______________________

Whom may we thank for referring you to our office? ______________________________

***Thank you and welcome to our office! We appreciate the confidence you place with us to provide complete dental services for you and your family. If you have any questions, please don't hesitate to ask.***

## MEDICAL HISTORY

1.) Are you presently under the care of a physician? . . . . . . . . . . ☐ Yes ☐ No
   *If yes, for what reason.* ______________________________

2.) Have you had any serious operations or illnesses? . . . . . . . . . . ☐ Yes ☐ No
   *If yes, please explain* ______________________________

3.) **(Women)** Are you pregnant or nursing? . . . . . . . . . . ☐ Yes ☐ No
   Are you taking birth control pills? . . . . . . . . . . ☐ Yes ☐ No
   Are you on hormone replacement therapy? . . . . . . . . . . ☐ Yes ☐ No
   Are you taking medication for bone density? (Bisphosphonate) . . . . . . . . . . ☐ Yes ☐ No
   *If yes, when did treatment begin?* ______________________________
   *If yes, which one(s): Oral: Actonel, Boniva, Didronel, Skelid, Fosamax*
   *IV: Aredia, Zometa, Reclast*

4.) Have you ever been advised to take antibiotics prior to any dental work? . . . . . . . . . . ☐ Yes ☐ No

5.) Are you taking any prescription or over the counter drugs or medications? . . . . . . . . . . ☐ Yes ☐ No
   Please List: ______________________________
   ______________________________
   ______________________________

6.) Are you allergic or hypersensitive to any of the following:

| | | | | | |
|---|---|---|---|---|---|
| Codeine | ☐ Yes | ☐ No | Penicillin | ☐ Yes | ☐ No |
| Latex (Balloons, etc.) | ☐ Yes | ☐ No | Tetracycline | ☐ Yes | ☐ No |
| Local Anesthesia | ☐ Yes | ☐ No | Other: ______________ | | |

7.) Do you have or have you ever had or received treatment for:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Rheumatic Fever | ☐ Yes | ☐ No | Diabetes | ☐ Yes | ☐ No | Artifical Joints | ☐ Yes | ☐ No |
| Congenital Heart Defect | ☐ Yes | ☐ No | Healing Complications | ☐ Yes | ☐ No | Epilepsy Or Seizures | ☐ Yes | ☐ No |
| Abnormal Heart Condition | ☐ Yes | ☐ No | Blood Disorders | ☐ Yes | ☐ No | Chemical Dependency | ☐ Yes | ☐ No |
| Artifical Heart Valve | ☐ Yes | ☐ No | Hepatitis: Type ______ | ☐ Yes | ☐ No | Glaucoma | ☐ Yes | ☐ No |
| Heart Attack | ☐ Yes | ☐ No | Autoimmune Disorder | ☐ Yes | ☐ No | Cancer | ☐ Yes | ☐ No |
| Cardiac Pacemaker | ☐ Yes | ☐ No | Organ Transplant | ☐ Yes | ☐ No | Chemotherapy/ | | |
| Mitral Valve Prolapse | ☐ Yes | ☐ No | Sjögren's Syndrome | ☐ Yes | ☐ No | Radiation Treatment | ☐ Yes | ☐ No |
| Heart Murmur | ☐ Yes | ☐ No | AIDS/HIV | ☐ Yes | ☐ No | Kidney Disease | ☐ Yes | ☐ No |
| High Blood Pressure | ☐ Yes | ☐ No | Venereal Disease | ☐ Yes | ☐ No | Psychological Concerns | ☐ Yes | ☐ No |
| Low Blood Pressure | ☐ Yes | ☐ No | Lung Disease | ☐ Yes | ☐ No | Sinus Problems | ☐ Yes | ☐ No |
| Blood Thinning Treatment | ☐ Yes | ☐ No | (Including Asthma & TB) | | | Heartburn/Acid Reflux | ☐ Yes | ☐ No |
| Stroke | ☐ Yes | ☐ No | Arthritis | ☐ Yes | ☐ No | Sleep Apnea/Snoring | ☐ Yes | ☐ No |

Any Other Medical Conditions ______________________________ Over →

## DENTAL HISTORY

1.) Date of last dental visit ______________________
2.) Are you having any dental pain? ☐ Yes ☐ No
3.) Are you dissatisfied with the appearance of your teeth? ☐ Yes ☐ No
4.) Have you had any head, neck or jaw injuries? ☐ Yes ☐ No
5.) Do you clench or grind your teeth? ☐ Yes ☐ No
6.) Do you have jaw/TMJ problems? ☐ Yes ☐ No
7.) Do you have problems with thirst/dry mouth? ☐ Yes ☐ No
8.) Have you had a history of bleeding gums or Periodontal disease? ☐ Yes ☐ No
9.) Do you have or have you had any problems with sores, lumps or ulcers in your mouth? ☐ Yes ☐ No
10.) Any tobacco use (past/present) ☐ Yes ☐ No
Type ________________ Amount ______________________

***To the best of my knowledge, the above information is complete and correct. I will notify my dental health practitioner when any change occurs.***

*Signature—(Patient/Guardian if under 18)* ______________________ *Date* ______________

## ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with ______________________ and assign directly to Franco & Associates Family and Cosmetic Dentistry, all benefits, if any, otherwise payableto me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

SIGNATURE ______________________ DATE ______________

## MINOR/CHILD RELEASE

I, being the parent or guardian of ______________________ , do hereby request and authorize the dental staff to perform necessary dental services for my child. These services include but are not limited to dental radiography (x-rays) and the administration of anesthetics which deem advisable by the dentist, whether or not I am present at the actual appointment when the treatment is rendered.

SIGNATURE ______________________ DATE ______________

## MISSED APPOINTMENTS

Your appointment reserves our office and professional staff exclusively for you. Missed appointments increase the cost of care for all our patients. Appointments canceled with less than 24 hours notice, or missed completely, are billed directly to you at $50.00 per appointment.

SIGNATURE ______________________ DATE ______________

## FOR OFFICE USE ONLY

| Date | Medical History Changes | BP | Patient Signature | Int. |
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