Shelton DENTAL CENTER

Patient Information

Today's Date_____

Name_____
Last First Middle Initial Preferred Name

☐Male ☐Female ☐_____ Preferred Pronouns_____ Birth date_____ Age_____

Address_____

City_____ State_____ Zip Code_____

Phone(home)_____ Phone(cell)_____ Phone(work)_____

E-mail address_____ May we contact you at work? ◊ yes ◊no

Social Security #_____ Occupation_____

Employer Name_____

Employer Address_____

Emergency Contact Name_____

Phone(home)_____ Phone(cell)_____ Phone(work)_____

Spouse's Employer_____

Employer Address_____

Whom may we thank for referring you to us? _____

Primary Dental Insurance

Subscriber Name_____ Social Security #_____ DOB_____

Employer Name and Address_____

Insurance Co. Name and Address_____

_____ Insurance Co. Phone_____

Group #_____ Policy/Subscriber ID#_____

Relationship to Patient_____

Secondary Dental Insurance

Subscriber Name_____ Social Security #_____ DOB_____

Employer Name and Address_____

Insurance Co. Name and Address_____

_____ Insurance Co. Phone_____

Group #_____ Policy/Subscriber ID#_____

Relationship to Patient_____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance carriers and assign directly to Shelton Dental Center all insurance benefits, if any, otherwise payable directly to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance and regardless if I have insurance. I hereby authorize my dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. The information on this page and the medical history are correct to the best of my knowledge.

Responsible Party (print) _____ Relation to patient_____

Signature _____ Date_____

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Medical History

Please check all that apply

Conditions:

- ☐ Abnormal bleeding
- ☐ Alcohol or Drug Abuse
- ☐ Aids/HIV
- ☐ Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Asthma
- ☐ Blood Pressure: hi or low
- ☐ Blood transfusions
- ☐ Bisphosphonates
- ☐ Cancer/chemotherapy
  Date_____
- ☐ Diabetes
  A1C/date_____
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ COPD
- ☐ Epilepsy
- ☐ Fever Blisters/Herpes
- ☐ Heart Attack :
  Date_____
- ☐ Heart Murmur/Defect
- ☐ Heart Surgery
  Date_____
- ☐ Hemophilia/bleeding
- ☐ Hepatitis : Type_____
- ☐ Joint Replacement :
  Date_____
- ☐ HRT hormone replacement
- ☐ Kidney Problems
  Dialysis: Y N
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Pacemaker
- ☐ Psychiatric Disease
- ☐ Radiation therapy
  Area of body_____
  Date_____
- ☐ Seizures
- ☐ STD
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Sleep Apnea
  CPAP used: Y N
- ☐ Stroke/TIA
  Date_____
- ☐ Thyroid
  - ☐ hypothyroidism
  - ☐ hyperthyroidism
  - ☐ thyroid removed
    Date_____
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other_____

Allergies to:

- ☐ Aspirin
- ☐ Codeine
- ☐ Anesthetics
- ☐ Latex
- ☐ Metals/Jewelry/Nickel
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Other_____

Miscellaneous:

Do you smoke? ☐yes ☐no
Do you chew? ☐yes ☐no
Do you vape? ☐yes ☐no
Do you use marijuana?
☐yes
☐no

If Female:

Are you taking Birth Control Pills? ☐yes ☐no

Are you Pregnant?
☐yes
☐no

Do you take pre-medication (antibiotic) before dental treatment: ☐yes ☐no

If yes, what kind?_____ Reason_____

Current Medications, Suppliments, and dosage:

_____

_____

_____

_____

Physician Information:

Name of Physician_____ Phone_____

Name of Specialist Physician_____ Phone_____

Pharmacy Information:

Name/location_____ Phone_____