MILFORD FAMILY DENTISTRY

Welcome to our office!

DATE _____

PLEASE FILL IN THE INFORMATION REQUESTED BELOW.

PATIENT'S NAME (PRINT) ☐ CHILD ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOW | BIRTHDATE | SOC. SEC. # | HOME PHONE / CELL PHONE

STREET ADDRESS | CITY | STATE | ZIP | EMAIL

PERSON RESPONSIBLE FOR BILL | ADDRESS | SOC. SEC. # | REFERRED BY ☐ PATIENT ☐ AD ☐ OTHER

PRESENT OCCUPATION (OF PARENTS IF CHILD PATIENT) | EMPLOYER | ADDRESS | BUSINESS PHONE

SPOUSE'S NAME & OCCUPATION | EMPLOYER | ADDRESS | BUSINESS PHONE

☐ DENTAL INSURANCE (PRIMARY) | POLICY HOLDERS NAME | INS. CO. NAME | BIRTHDATE | SOC. SEC. # or POLICY #

☐ SPOUSE DENTAL INS. (SECONDARY) | EMPLOYEE | INS. CO. NAME | BIRTHDATE | SOC. SEC. #

I authorize Milford Family Dentistry to treat me, my child, or named patient for which I am guardian. I understand that there are medical risks associated with any treatment and that local anesthetics (novacaine) which may be used for treatment can have side effects, including but not limited to such effects as shakiness, nervousness, allergic reactions or fainting. I consent to the treatment Milford Family Dentistry has recommended and realize that there may be consequences to an alternative treatment or no treatment at all.

DATE _____ SIGNATURE _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Milford Family Dentistry to furnish information to insurance carriers concerning my dental diagnosis and treatment and hereby assign to them all payments for dental services rendered to myself or my dependents. I also permit a copy of this signature to be held on file and used in place of the original for insurance purposes.

DATE _____ SIGNATURE _____

CURRENT PHYSICIAN | NAME | ADDRESS | CITY | PHONE

☐ NONE

LIST ANY MEDICAL CONDITIONS OR TREATMENT IN THE LAST 12 MONTHS.

☐ NONE

LIST ANY DRUGS OR MEDICATIONS CURRENTLY BEING USED.

☐ NONE

LIST ANY KNOWN ALLERGIES TO DRUGS, MEDICATIONS, ETC.

☐ NONE ☐ PENICILLIN OTHER:

PLEASE CHECK ANY CONDITION BELOW WHICH YOU HAVE HAD

☐ HEART DISEASE
☐ HEART MURMUR OR MVP
☐ HIGH BLOOD PRESSURE
☐ RHEUMATIC FEVER
☐ HEPATITIS
☐ TUBERCULOSIS
☐ DIZZINESS OR EPILEPSY
☐ STOMACH AILMENT
☐ CYSTS, TUMORS, OR GROWTH
☐ AIDS
☐ ARTIFICIAL JOINTS
☐ PREGNANT (AT PRESENT)
☐ BREATHING OR LUNG PROBLEM
☐ DIABETES
☐ KIDNEY OR LIVER PROBLEM
☐ NERVOUS OR MENTAL PROBLEM
☐ VENEREAL DISEASE
☐ RADIATION THERAPY
☐ BLOOD OR BLEEDING DISORDER
☐ ARTHRITIS
☐ NONE OF THE PRECEDING

REV RMH			

☐ Other-Please explain medical conditions

☐ Name of nearest relative not living with you & phone number

REASON FOR TODAY'S VISIT (CHECKUP, TOOTHACHE, ETC.)

TIME SINCE LAST DENTAL EXAM

REGARDING DENTAL WORK IN GENERAL, ARE YOU APPREHENSIVE?
☐ NO ☐ MODERATELY ☐ VERY ☐ TERRIFIED

IF YOU HAVE QUESTIONS OR CONCERNS ABOUT ANY OF THE FOLLOWING, PLEASE CHECK:

☐ TOOTH SENSITIVITY
☐ CAVITIES
☐ WISDOM TEETH
☐ GUM PROBLEMS
☐ CROWNS (CAPS)
☐ BRIDGEWORK
☐ IMPLANTS
☐ PARTIAL DENTURES
☐ FULL DENTURES
☐ ROOT CANALS
☐ ORTHODONTICS
☐ BONDING
☐ SEALANTS
☐ INVISALIGN
☐ JAW JOINT (TMJ)
☐ FLOSSING
☐ BLEACHING
☐ MISSING TEETH
☐ SMILE ANALYSIS
☐ OTHER (SPECIFY)_____

Thank You. Please return this form to the front desk.