Welcome!

AVONDENTAL GROUP

Complete Dental Services for Your Entire Family

PATIENT INFORMATION

Legal Name_____ Nickname _____

Address_____ City_____ State_____ Zip_____

Home Telephone_____ Work Telephone_____ Cell Phone_____

***Please circle the telephone number that you would like us to use first when contacting you.*

Email Address_____ Sex: M / F Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Date of Birth_____/_____/_____ Social Security Number_____/_____/_____ Occupation_____

Person Responsible for Payment_____ Relationship to Patient_____

Responsible Party's Address_____ City_____ State_____ Zip_____

Person to contact in case of emergency_____ Telephone #_____

Whom may we thank for referring you to us?_____

DENTAL INSURANCE INFORMATION

Name of Insured_____ Relationship to Patient_____

Social Security Number_____ Date of Birth_____/_____/_____ Date Employed_____

Name of Employer_____ Employer Telephone_____

Employer Address_____ City_____ State_____ Zip_____

Dental Insurance Company_____ Insurance Telephone_____

Insurance Address_____ City_____ State_____ Zip_____

Group #_____ Subscriber #_____ Effective Date_____

SECONDARY DENTAL INSURANCE INFORMATION

If you have secondary insurance, please request a separate insurance form. Thank you.

AVON DENTAL GROUP POLICY AUTHORIZATION

I certify that the information provided above is accurate to the best of my knowledge. I authorize Avon Dental Group to release any information including the diagnosis and the records of my treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and I agree to be responsible for payment of all services rendered on my behalf and my dependents. I further understand that appointments broken or canceled on the same day may be subject to a $25 fee, and that a billing charge of $5 will be charged on the third billing cycle of non payment.

_____ _____

Signature of patient (or parent or legal guardian) Date

Patient Name_____

DENTAL HISTORY

Former Dentist _____ Date of Last Exam _____

Reason for today's visit _____ Date of last X-rays_____

How often do you brush your teeth? _____ How often do you floss?_____

How do you feel about the appearance of your teeth?_____

Please check any of the following conditions that apply to you:

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Jaw Pain
- ☐ Grinding of teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sores or growths in mouth
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when chewing
- ☐ Sensitivity to cold
- ☐ Snoring
- ☐ Sleep Apnea

Have you had a **Sleep Study?**

☐ Yes ☐ No

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit_____

Please list any allergies_____

Please list all medications you are taking: _____

_____

Please check any of the following that apply to you:

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Back problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Cortisone Treatments
- ☐ Cough (persistent)
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ HIV Positive
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Nervous Problems
- ☐ Psychiatric Care
- ☐ Radiation
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ STD
- ☐ Stroke
- ☐ Swelling (Ankles or Feet)
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other _____

Heart Problems

- ☐ Artificial Heart Valve
- ☐ Circulatory Problems
- ☐ Congenital Heart Defect
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ History of Endocarditis
- ☐ Pacemaker
- ☐ Other _____

Do you need to **Pre-Medicate** due to a heart condition or a joint replacement?

☐ Yes ☐ No

***Women Only Please – Are you pregnant or nursing?* _____ *Are you taking birth control?* _____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

_____

Signature of patient (or parent or legal guardian) Date Reviewed by Doctor

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

_____ _____ _____ Dr. _____

_____ _____ _____ Dr. _____

_____ _____ _____ Dr. _____

_____ _____ _____ Dr. _____

_____ _____ _____ Dr. _____

_____ _____ _____ Dr. _____

Date Exceptions Patient's Signature Reviewed by: