ALBEMARLE
DENTAL ASSOCIATES

Have you ever had any of the following medical problems or conditions? (Please check)

- ☐ Abnormal bleeding
- ☐ Abnormal blood pressure
- ☐ Allergies / hay fever / sinus
- ☐ Alcohol / drug abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting spells
- ☐ Frequent headaches
- ☐ Glaucoma
- ☐ HIV / AIDS
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Heart surgery
- ☐ Hepatitis
- ☐ Herpes / fever blisters
- ☐ Joint replacement
- ☐ Liver disease
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Pacemaker
- ☐ Are you Pregnant
  Due date _____
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle cell disease
- ☐ Sinus problems
- ☐ Stroke
- ☐ Transplant
- ☐ Tobacco use
- ☐ Radiation treatment

Assignment and Release

I, the undersigned, assign directly to Albemarle Dental Associates all benefits of my insurance, if any, otherwise payable to 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: _____

I, being the parent or guardian of _____, do hereby authorize the dental staff to perform all necessary dental services for my child, including but not limited to x-rays, and for the administration of anesthetics which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Signature_____ Date: _____

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HEALTH HISTORY

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

Date of last dental visit

Reason for today's visit

Do you have a primary physician?

◯ Yes ◯ No

Name address and phone number of physician

Please list any medications you are now taking

Do you require premedication for dental treatment?

◯ Yes ◯ No

Are you allergic to or had an adverse reaction to any of the following? (Please check)

☐ Penicillin ☐ Erythromycin ☐ Sulfa Drugs ☐ Aspirin

☐ Codeine ☐ Latex ☐ Any metals (List)

Are you allergic to any drug not listed above? (List)

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Spouse or Responsible Party Information

Social Security #: ☐☐☐-☐☐-☐☐☐☐

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female

Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____

_____ (City) ____ (State) _____ (Zip Code)

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____

_____ (City) ____ (State) _____ (Zip Code)

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WELCOME!

Thank you for selecting our dental office. To help us to best meet all of your dental health care needs, please complete this form as completely and accurately as possible. If you have any questions or need assistance, please ask us and we will be glad to help.

PATIENT INFORMATION

Social Security #: ☐☐☐-☐☐-☐☐☐☐

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ○ Male ○ Female

Family Status: ○ Married ○ Single ○ Child ○ Other

Birth Date: _____ Prev. Visit: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____

_____ (City) _____ (State) _____ (Zip Code)

Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Medical Office ☐ Yellow Pages ☐ Internet

☐ Newspaper ☐ Work ☐ Other (name below)

Name of person, office, or other source referring you to our practice:

Do you have dental insurance coverage?

○ Yes ○ No