PERRY DENTAL

PATIENT INFORMATION

DATE

PATIENT'S NAME | BIRTH DATE | AGE

ADDRESS | CITY | ZIP

SEX ☐ M ☐ F | PATIENT'S SOC. SEC. NO. | MARITAL STATUS: ☐ M ☐ S ☐ W ☐ D

PATIENT'S EMPLOYER | OCCUPATION

HOME PHONE # | WORK PHONE # | CELL PHONE #

EMAIL ADDRESS

HOW WOULD YOU LIKE TO BE CONTACTED? ☐ PHONE ☐ CELL PHONE ☐ TEXT ☐ EMAIL

PERSON TO CONTACT IN CASE OF EMERGENCY

ADDRESS | PHONE #

RELATIONSHIP TO PATIENT

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY'S NAME | BIRTH DATE

RESIDENCE ADDRESS | CITY | ZIP

HOME PHONE # | CELL PHONE # | SOC. SEC. NO.

EMPLOYER | EMPLOYER PHONE #

EMPLOYER ADDRESS | CITY | ZIP

WILL DENTAL INSURANCE BE INVOLVED? ☐ YES ☐ NO ** IF YES, PLEASE COMPLETE NEXT SECTION**

PRIMARY INSURANCE INFORMATION

SUBSCRIBER'S NAME | SOC. SEC. NO.

RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER (explain) | BIRTH DATE

NAME OF INSURANCE COMPANY | INSURANCE ID #

GROUP NO. | ADDRESS

SUBSCRIBER'S EMPLOYER | EMPLOYER PHONE #

SECONDARY INSURANCE INFORMATION

SUBSCRIBER'S NAME | SOC. SEC. NO.

RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER (explain) | BIRTHDATE

NAME OF INSURANCE COMPANY | INSURANCE ID #

GROUP NO. | ADDRESS

SUBSCRIBER'S EMPLOYER | EMPLOYER PHONE #

Date	Changes	Initials	Date	Changes	Initials	Date	Changes	Initials	Date	Changes	Initials

PERRY DENTAL

Patient's Health History

Name _____ Birth Date _____

Has another dentist treated you in the past? Name _____ Phone # _____

Medical doctor's name _____ Phone # _____

Describe your general health _____

Have you had or do you have any serious illness? _____ Past surgery _____

Undergone general anesthesia ? _____ When ? _____

Are you presently under a doctor's care? _____ For what? _____

Are you presently taking any medications, including birth control? _____

List medications and why you are taking them _____

_____

Have you had or do you now have any of the following?

Anemia or Bleeding Disorder	☐ yes ☐ no	Asthma, Tuberculosis, Breathing Problems	☐ yes ☐ no
Diabetes	☐ yes ☐ no	Cancer	☐ yes ☐ no
Rheumatic Fever	☐ yes ☐ no	Hepatitis or HIV (AIDS) positive	☐ yes ☐ no
High or Low Blood Pressure	☐ yes ☐ no	Artificial Joints	☐ yes ☐ no
Heart Disease	☐ yes ☐ no	Taken Phen-Fen	☐ yes ☐ no
Heart Murmur	☐ yes ☐ no	Are you pregnant?	☐ yes ☐ no

Do you have any allergies or adverse reactions to medications or drugs? ☐ yes ☐ no Please list _____

Do you know of any other information that might affect your dental treatment? _____

Health Questionnaire Acknowledgment and Consent to Proceed: *I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.*

I authorize the dentists of Perry Dental and/or such associates or assistants as she/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, temporary or rarely, permanent numbness, and muscle soreness. I understand that there are risks associated with ALL dental treatments including, but not limited to: permanent numbness, pain, swelling, unsuccessful treatment, etc. I understand that as a result of dental treatment, including preventative procedures such as cleaning and basic dentistry, as well as fillings of all types, the teeth, gums and surrounding areas may remain sensitive or even possibly quite painful both during and after completion of treatment.

CONSENT FOR TREATMENT I hereby grant authority to the dentist(s) in charge of the patient whose name appears on the Health History form to administer any treatment or to administer such anesthetics, analgesics, sedatives and nitrous oxide sedation, and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of the patient. I have read the above terms and conditions and consent for treatment and fully agree to their content.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Signed _____ Date _____ Relationship _____

Date	Changes	Initials	Date	Changes	Initials	Date	Changes	Initials	Date	Changes	Initials