Accent dental

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MEDICAL ALERT

PATIENT INFORMATION (Please Print) ☐ M ☐ F

☐ Dr.
☐ Mr.
☐ Ms.
Patient's Name: ☐ Mrs. _____ Birthdate ____/____/____
☐ Miss LAST FIRST MIDDLE MO. DAY YR.

Home Address _____ Home Phone _____
POSTAL CODE

Employer _____ Bus. Phone _____

Previous Dentist _____ Physician _____ Care Card _____

Email Address _____

SPOUSE/COMMON LAW INFORMATION (if applicable)

Name _____ Birthdate ____/____/____
MO. DAY YR.

Employer _____ Bus. Phone _____

IF PATIENT IS A MINOR

Father _____ Employer _____ Bus. Phone _____

Mother _____ Employer _____ Bus. Phone _____

PARENT'S CONSENT *I hereby authorize necessary dental services for* _____

Emergency Contact _____

Signature _____

*Whom may we thank for referring you to our office? _____

PRIMARY DENTAL INSURANCE

NAME OF INSURED	DATE OF BIRTH Y: M: D:
EMPLOYER	
INSURANCE CARRIER	
GROUP/POLICY NUMBER	DIVISION
I.D. NUMBER OR S.I.N.	CERTIFICATE NUMBER / DEP. No.
COVERAGE PERCENTAGE A B C D	
LIMITS BASIC MAJOR ORTHO	
DEDUCTIBLE BASIC MAJOR	☐ PER PERSON ☐ PER FAMILY

SECONDARY DENTAL INSURANCE

NAME OF INSURED	DATE OF BIRTH Y: M: D:
EMPLOYER	
INSURANCE CARRIER	
GROUP/POLICY NUMBER	DIVISION
I.D. NUMBER OR S.I.N.	CERTIFICATE NUMBER / DEP. No.
COVERAGE PERCENTAGE A B C D	
LIMITS BASIC MAJOR ORTHO	
DEDUCTIBLE BASIC MAJOR	☐ PER PERSON ☐ PER FAMILY

Person Responsible for Account: ☐ **Self** ☐ **Spouse** ☐ **Other** _____

- I acknowledge full responsibility for the payment of all dental services and agree to pay for them in full at the time of service unless other financial arrangements have been made.
- A service charge of 2.5% per month or 30% per annum will be applied to accounts with balances over 30 days.

MEDICAL HISTORY **To assist in proper diagnosis and treatment**

Name of physician _____

Date of last physician visit _____

	Yes	No
Reason _____		
Do you have any general health problems? _____	☐	☐
Do you routinely take any medication? *(including non-prescription)* _____ (please list on last page of this form)	☐	☐
Are you presently under the care of a physician? _____	☐	☐
Have you been treated in hospital within the last two years for any reason? _____	☐	☐
Do you use tobacco? If so how often? _____	☐	☐
Do you use a controlled substance? _____	☐	☐
Do you have a history of drug dependency? _____	☐	☐
Have you ever had one of the following		
Tuberculosis or lung disease _____	☐	☐
Ulcer or stomach problems _____	☐	☐
Any unusual reactions/allergies to: a. Penicillin _____	☐	☐
b. Aspirin _____	☐	☐
c. Codeine _____	☐	☐
d. Any other _____	☐	☐
High or low blood pressure _____	☐	☐
Joint replacement _____	☐	☐
Heart problems or stroke _____	☐	☐
Rheumatic fever or rheumatic heart _____	☐	☐
Prolonged bleeding from a minor cut _____	☐	☐
Hepatitis or liver trouble Hepatitis A ☐ B ☐ C ☐ D ☐ _____	☐	☐
Asthma or sinus problems _____	☐	☐
Arthritis or rheumatism _____	☐	☐
Diabetes or glaucoma _____	☐	☐
Kidney or thyroid problems _____	☐	☐
Nervous problems or epilepsy _____	☐	☐
Heart murmur _____	☐	☐
X-ray radiation therapy _____	☐	☐
Are you pregnant _____	☐	☐
Tested positive to HIV Virus _____	☐	☐

DENTAL HISTORY

Date of last dental examination _____

	Yes	No
Date of last dental x-ray _____		
Do you have regular checkups _____	☐	☐
Do you use dental floss regularly _____	☐	☐
Have you had professional instruction on home care _____	☐	☐
Are you presently having dental pain _____	☐	☐
Are you aware of any decayed teeth _____	☐	☐
Do you have rough or broken fillings _____	☐	☐
Are your teeth sensitive to: heat/cold _____	☐	☐
sweets _____	☐	☐
bite pressure _____	☐	☐
Does food catch between any teeth _____	☐	☐
Do your gums bleed when you brush _____	☐	☐
Are you ever aware of bad breath _____	☐	☐
Do you clench or grind your teeth _____	☐	☐
Do you want to improve the appearance of your teeth _____	☐	☐

Signature _____ Date _____

FOR PATIENTS WITH DENTURES/PARTIALS

	Yes	No
How long have you worn dentures _____		
How old is this set _____		
Has your denture been relined _____	☐	☐
Is your denture comfortable _____	☐	☐
Do you use denture adhesive _____	☐	☐
Are you satisfied with the appearance of your dentures _____	☐	☐
Do your dentures cause sore spots _____	☐	☐

FOR THE CHILD PATIENT

	Yes	No
Does your child brush regularly _____	☐	☐
Has your child had many cavities _____	☐	☐
Have your child's teeth been treated with fluoride _____	☐	☐
Is your child apprehensive about dental visits _____	☐	☐

ATTITUDES TOWARDS DENTISTRY

	Yes	No
Do you experience anxiety about dental treatment _____	☐	☐
Has anxiety postponed needed dental treatments _____	☐	☐
Do you expect to be able to keep your remaining teeth _____	☐	☐
How would you rate the quality of your past dental treatment _____		
_____		
Would you like to know about sedative techniques available _____	☐	☐

Thank you for taking the time to complete your medical and insurance information. If you do not inform us of future changes we will assume this information remains correct.

Once we have received your complete dental insurance information from you, we will submit claims on your behalf. It is the policy holder's responsibility to inform us of any changes, limitations and terminations.

Everyone's time is valuable; therefore, we make every attempt to run on schedule. In turn, we ask that you reserve time with us when you know it is convenient. If a change in your appointment is necessary, we ask that you give us two business days notice to reschedule. If two business days notice is not given there will be a charge of $50.00 for every 30 minutes reserved.

Thank you for your time and welcome to our office!

I, the undersigned certify that all medical and personal information provided is true to the best of my knowledge. I have read and understood all aspects of this form and comply with the policies outlined above. I also consent to my physician being contacted if necessary as this information may be required for my dental care.

Patient: _____
Please Print

Patient, Parent,
Guardian signature: _____

If Parent or Guardian,
please print name: _____

Date: _____/_____/_____
(mm) (dd) (yyyy)

I understand that by signing above I am also consenting to receive periodic email/text communications from Accent Dental.

Current Medications

____

____

Allergies to Medications

____

____

Date	Medical Update	PT 1 Initial	Provider Initial