FRANKLIN DENTAL Associates

Patient Information

Patient Name: _____ *Date:* _____
Date of Birth: _____ *Male* _____ *Female* _____ *Married* _____ *Single* _____ *Other*_____
Mailing Address:
_____

Email: _____ *Cell Phone:* _____*Cell Phone Carrier:*_____
Home Phone: _____. *I grant my permission to telephone/text/email me regarding matters related to my dental treatment.*

Health Information

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

How often do you: brush _____per day, floss _____ per day, use fluoridated mouth rinse _____per day
Have you ever experienced complications following dental treatment? If yes, please explain:
_____
Date of last dental exam: _____ ***How often do you visit the dentist:*** _____
Reason for today's visit: _____
Are you under a physician's care now? Yes No If yes, please explain: _____
Primary Care Physician: _____ phone number: _____
Have you ever had a head or neck injury or been hospitalized for a major operation? Yes No
Are you taking any medications, supplements, pills, or drugs? Yes No If yes, please list:
_____
_____
Preferred Pharmacy information; _____
Do you use tobacco? Yes No
Do you use controlled substances/recreational drugs? Yes No
Do you need to pre-medicate prior to dental appointments? Yes No If yes, please explain: _____
Women: Are you Pregnant/Trying to get pregnant? Yes No Nursing? Yes No
Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain:_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No	Sleep Apnea	Yes	No

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Responsible Party

Name: _____ Self _____ Spouse _____ Parent _____

Birthdate: _____Social Security Number: _____

Email: _____ Cell phone: _____ Home Phone: _____

Insurance Information

Primary Dental Insurance

Name of Insured: _____ Self_____ Spouse_____ Parent _____
Insured Birthdate: _____Insured Employer: _____
Insurance Plan Name and Address:
_____
_____

Insured ID Number:_____ Insured Group Number: _____

Secondary Dental Insurance

Name of Insured: _____ Self_____ Spouse_____ Parent _____
Insured Birthdate: _____Insured Employer: _____
Insurance Plan Name and Address:
_____
_____

Insured ID Number:_____ Insured Group Number: _____

Medical Insurance for Oral Surgery services

Name of Insured: _____ Self_____ Spouse_____ Parent _____
Insured Birthdate: _____Insured Employer: _____
Insurance Plan Name and Address:
_____
_____

Insured ID Number:_____ Insured Group Number: _____

Consent for Services

I consent to dental treatment by Franklin Dental Associates. As a condition to consent, all dental services performed without previous financial arrangements, must be paid at the time the services are performed. Patients who carry dental insurance understand that Franklin Dental Associates will help prepare the insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, Franklin Dental Associates cannot render services on the assumption that our charges will be paid by an insurance company.
In consideration for the professional services rendered to me, or at my request by Franklin Dental Associates, I agree to pay Franklin Dental Associates for said services at the time services are rendered. I further agree that the cost of said services shall be billed to my insurance unless objected to, by me, in writing.

Signature: _____ Self_____ Spouse _____ Parent_____ Date: _____

Signature parent or guardian: _____ Date: _____