Patient Information

Patient Name: _____ Date: _____

Date of Birth: _____ Male _____ Female _____ Married _____ Single _____ Other_____

Mailing Address: _____

Email: _____ Cell Phone: _____Carrier:_____ Home Phone: _____

I grant my permission to telephone/text/email me regarding matters related to my dental treatment.

Health Information

Have you ever had any of the following? Please check all that apply:

Anemia	Epilepsy	History of cold sores	Radiation Treatment
Anxiety	Excessive Bleeding	HIV	Respiratory Problems
Arthritis	Fainting	Jaundice	Rheumatic Fever
Artificial Joints	Glaucoma	Kidney Disease	Sinus Problems
Asthma	Head Injuries	Liver Disease	Stomach Problems
Blood Disease	Heart Disease	Osteoporosis	Stroke
Cancer	Heart Murmur	Pacemaker	Tuberculosis
Diabetes	Hepatitis	Pregnancy/Due Date:_____	Tumors
Dizziness	High Blood Pressure		

Other: _____ Allergies: _____

Do you or have you used: Alcoholic beverages _____ Tobacco _____ Recreational Drugs _____

Premedication for Dental Visits: _____Pharmacy of choice: _____

Previous Dental Office: _____Date of Last Dental Visit: _____

Current Dental Concerns: _____

Have you ever experienced complications following dental treatment? If yes, please explain:
_____

Have been admitted to a hospital or needed emergency care during the past two years? If yes, please explain:
_____

Are you currently under the care of a physician for any health problem? If yes, please explain:
_____

Name of Physician: _____ Phone: _____

Are you currently taking medication? If yes, please provide a list medications:
_____

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

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.

I consent to dental treatment by Franklin Dental Associates.

As a condition of your consent to treatment by Franklin Dental Associates, 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 patients 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: _____