101 DENTAL & ORTHODONTICS
WWW.101DENTAL.COM YOUR MOST COMPREHENSIVE & CONVENIENT DENTAL SERVICE

PATIENT INFORMATION FORM

Patient Information

Last Name _____ **First** _____**Middle Initial** _____

Name of Guardian if patient is a minor:_____

Circle one: □ Dr. □ Mr. □ Mrs. □ Ms. **Gender**: □ male □ female

Birth Date: ____/_____/____ SSN#:_____-_____-_____ DL# __ __ __ __ __ __ __ __

Address: _____

City/State/Zip_____

Email Address: _____

Home Telephone #_____ Work #_____ext. _____

Fax #: _____Pager #: _____Cell #: _____

Employer:_____ Position/Title_____ # of yrs_____

Business Address:_____

Spouse's Name _____ Work # : _____ext: _____

In case of Emergency contact: _____Relation:_____#:_____

Dental History

Name of Previous Dentist: _____ Phone#_____

Date of last dental visit: _____ Date of last cleaning: _____Date of last X-Ray_____

Dental Insurance

Insurance Co. Name:_____ Group#: _____

Customer Service 1 800 _ _ _ -_ _ _ _ ID Number: _____

Who is the insured member in you family? □ Yourself □ Spouse □ Other

Insured's DOB _____ Insured's SS#___ ___ ___ - ___ ___ - ___ ___ ___ ___

Insured's Employer: _____ Wk#: _____

Dental Claim Agreements

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges to the extent permitted under applicable law, I authorize release of any information relating to any dental claims. I hereby authorize payment of the dental benefits otherwise payable to me directly 101 Dental and orthodontics.

_____

Patient/Parent Signature **Date**

FOR FASTER SERVICE PLEASE HAVE YOUR DRIVER LICENSE AND DENTAL INSURANCE CARD AVAIBLE.

WWW.101DENTAL.COM DENTAL & ORTHODONTICS
YOUR MOST COMPREHENSIVE & CONVENIENT DENTAL SERVICE

Medical History

Are you currently under the care of a physician?

Physicians Name: _____ Phone: _____

Date and reason of Last exam: _____

Do you have a current medical problem? Y/N Explain?

_____

_____

_____

Please list any prescription/over-the-counter drugs you are taking:

Name of Medication _____ dosage _____ for _____
Name of Medication _____ dosage _____ for _____
Name of Medication _____ dosage _____ for _____
Name of Medication _____ dosage _____ for _____

Medical History

Yes	No	Condition
☐	☐	ADD/ADHD – Attention Deficit Disorder/ Attention Hyperactivity Disorder
☐	☐	AIDS/HIV+
☐	☐	Anemia
☐	☐	Allergies
☐	☐	Asthma
☐	☐	Autism
☐	☐	Behavioral Problems
☐	☐	Birth defects
☐	☐	Blood Transfusions
☐	☐	Bone or Joint Problems
☐	☐	Brain Injury
☐	☐	Cerebral Palsy
☐	☐	Cancer/Tumor
☐	☐	Chemical Dependency
☐	☐	Chemotherapy/Radiation
☐	☐	Chicken Pox
☐	☐	Child Abuse
☐	☐	Cleft Palate/Lip
☐	☐	Cold Sore/Canker Sores
☐	☐	Developmentally Delayed: Age level is___
☐	☐	Diabetes
☐	☐	Earaches/Ear Infections
☐	☐	Epilepsy/Seizure Disorder
☐	☐	Eye Conditions
☐	☐	Females: Are you pregnant?

Medical History

Yes	No	Condition
☐	☐	Hearing Impairment
☐	☐	Heart Disease
☐	☐	Heart Defect
☐	☐	Heart Murmur
☐	☐	Hemophilia
☐	☐	Hepatitis/Liver Disease
☐	☐	High Blood pressure
☐	☐	Hospital Stay/Operation **(Please explain)**
☐	☐	Injury to Front Teeth
☐	☐	Kidney Disease
☐	☐	Low Blood Pressure
☐	☐	Lupus
☐	☐	Mentally Handicapped
☐	☐	Metallic Implant, Shunts, Pins/Rods
☐	☐	Mononucleosis
☐	☐	Premature Birth
☐	☐	Prolonged Bleeding When Cut
☐	☐	Psychiatric Care
☐	☐	Rheumatic Fever
☐	☐	Scarlet Fever
☐	☐	Sickle Cell Disease
☐	☐	Sore Throats
☐	☐	Speech Impairment
☐	☐	Thyroid Disease
☐	☐	Tonsillitis
☐	☐	Transplant (Please specify organ)

Name of Medication _____ dosage _____ for _____

Please list any other medical condition(s) and/ or serious illnesses that we should be aware of:

_____

_____

Are you allergic to or do you suffer ill effects from any of the following?

____ Penicillin ____ Codeine ____ Dental Anesthesia ____ Aspirin ____ Household Bleach ____ Nickel _____

____ Aspirin ____ Sulfa Drugs ____ Latex ____ Aspirin ____ Epinephrine ____ Other:_____

The information provided today is correct to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical status. I understand that this office will assist me in getting my insurance reimbursement but I am financially responsible for all charges whether or not paid by insurance. Payment is due in full at time of treatment unless prior arrangements have been approved.

Patient/Parent Signature **Date**

Doctor Signature **Date**