

Welcome to Aspen Dental Care, P.C.

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. This information is necessary for our files and will be considered confidential. We look forward to working with you in maintaining your dental health.

GENERAL PATIENT INFORMATION

DATE _____

PATIENT'S LAST NAME _____ FIRST NAME _____ MIDDLE _____ HOME PHONE _____ CELL PHONE _____

CURRENT STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____ HOW LONG? _____

PREVIOUS ADDRESS (IF LESS THAN 3 YEARS AT CURRENT ADDRESS) _____

SOCIAL SECURITY NUMBER _____ DRIVER'S LICENSE NUMBER _____ WORK PHONE _____

EMPLOYED BY _____ DO YOU PREFER PHONE, TEXT OR EMAIL REMINDERS? _____

OCCUPATION _____ DATE OF BIRTH _____ AGE _____ SEX: MALE FEMALE

NAME OF PERSON TO NOTIFY IN CASE OF EMERGENCY _____ RELATIONSHIP _____ EMERGENCY PHONE _____

CURRENT STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____ E-MAIL ADDRESS _____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY _____

ADDRESS _____ GROUP OR LOCAL NUMBER _____

SUBSCRIBER'S NAME _____ SUBSCRIBER'S SOCIAL SECURITY NUMBER _____ SUBSCRIBER'S I.D. NUMBER _____

SUBSCRIBER'S RELATIONSHIP TO PATIENT: SELF SPOUSE OTHER _____

SECONDARY INSURANCE COMPANY _____

ADDRESS _____ GROUP OR LOCAL NUMBER _____

SUBSCRIBER'S NAME _____ SUBSCRIBER'S SOCIAL SECURITY NUMBER _____ SUBSCRIBER'S I.D. NUMBER _____

SUBSCRIBER'S RELATIONSHIP TO PATIENT: SELF SPOUSE OTHER _____

HEALTH HISTORY

NAME OF CURRENT PHYSICIAN _____

PHONE _____

DATE OF LAST VISIT _____

HAVE YOU HAD: (PLEASE "X" EACH BOX IF THE ANSWER IS "YES", LEAVE BLANK IF ANSWER IS "NO")

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> CHRONIC FATIGUE SYNDROME | <input type="checkbox"/> GOUT | <input type="checkbox"/> RADIATION TREATMENT |
| <input type="checkbox"/> ADENOIDS REMOVED | <input type="checkbox"/> CHRONIC SINUS PROBLEMS | <input type="checkbox"/> HEADACHES | <input type="checkbox"/> RAPID WEIGHT GAIN/LOSS |
| <input type="checkbox"/> AIDS/HIV POSITIVE | <input type="checkbox"/> CIRCULATORY PROBLEMS | <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> ALCOHOLISM | <input type="checkbox"/> COCHLEAR IMPLANT | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> RHEUMATIC HEART DISEASE |
| <input type="checkbox"/> ALLERGIES/HAYFEVER | <input type="checkbox"/> CONGENITAL HEART DEFECT | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> SCARLET FEVER |
| <input type="checkbox"/> ANAPHYLAXIS | <input type="checkbox"/> CONVULSIONS/ SEIZURES | <input type="checkbox"/> HEART PACEMAKER | <input type="checkbox"/> SHINGLES |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> CORTISONE TREATMENTS | <input type="checkbox"/> HEART SURGERY | <input type="checkbox"/> SHORTNESS OF BREATH |
| <input type="checkbox"/> ANGINA PECTORIS | <input type="checkbox"/> COSMETIC SURGERY | <input type="checkbox"/> HEMOPHILIA | <input type="checkbox"/> SKIN RASH |
| <input type="checkbox"/> ARTHRITIS/RHEUMATISM | <input type="checkbox"/> COUGH PERSISTENT | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> SLEEP APNEA |
| <input type="checkbox"/> ARTIFICIAL HEART VALVES | <input type="checkbox"/> COUGH UP BLOOD | <input type="checkbox"/> HERPES | <input type="checkbox"/> SMOKING |
| <input type="checkbox"/> ARTIFICIAL JOINT (HIP/KNEE) | <input type="checkbox"/> CROHN'S DISEASE | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> SNORING |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> HIGH CHOLESTEROL | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> ANXIETY | <input type="checkbox"/> DIABETES | <input type="checkbox"/> IRRITABLE BOWEL SYND | <input type="checkbox"/> SURGICAL IMPLANT |
| <input type="checkbox"/> BACK PROBLEMS | <input type="checkbox"/> DIZZINESS/FAINTING | <input type="checkbox"/> JAW PAIN | <input type="checkbox"/> SYSTEMIC LUPUS ERYTH |
| <input type="checkbox"/> BLOOD DISEASE | <input type="checkbox"/> DRUG ADDICTION | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> SWELLING OF FEET/ANKLES |
| <input type="checkbox"/> BLOOD TRANSFUSION | <input type="checkbox"/> EMPHYSEMA/COPD | <input type="checkbox"/> LATEX ALLERGY | <input type="checkbox"/> THYROID DISEASE |
| <input type="checkbox"/> BIPOLAR DISORDER | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> TOBACCO USE |
| <input type="checkbox"/> BRUISES EASILY | <input type="checkbox"/> FEN-FEN USE | <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> TONSILITIS |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> FEVER BLISTERS | <input type="checkbox"/> MITRAL VALVE PROLAPSE | <input type="checkbox"/> TONSILS REMOVED |
| <input type="checkbox"/> CEREBRAL PALSY | <input type="checkbox"/> FIBROMYALGIA | <input type="checkbox"/> MULTIPLE SCLEROSIS | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> CHEMOTHERAPY | <input type="checkbox"/> GALL BLADDER PROBLEMS | <input type="checkbox"/> OSTEOPOROSIS | <input type="checkbox"/> ULCERATIVE COLITIS |
| <input type="checkbox"/> CHRONIC EAR PROBLEMS | <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> PSYCHIATRIC CARE | <input type="checkbox"/> VENEREAL DISEASE |

ANY DRUG OR FOOD ALLERGIES? _____

ANY OTHER MEDICAL CONDITIONS NOT LISTED ABOVE? _____

ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE? YES NO IF YES, DESCRIBE _____

ARE YOU BEING TREATED FOR CANCER OF ANY KIND? YES NO

HAVE YOU OR ARE YOU RECEIVING ANY DRUGS IN YOUR VEINS SUCH AS: A. AREDIA YES NO B. ZOMETA YES NO

MAY I HAVE YOUR PERMISSION TO SPEAK DIRECTLY WITH YOUR PHYSICIAN(S) REGARDING YOUR TREATMENT? YES NO

HAVE YOU EVER BEEN HOSPITALIZED? YES NO IF YES, DESCRIBE _____

WOMEN: ARE YOU PREGNANT? YES NO NURSING? YES NO TAKING BIRTH CONTROL PILLS? YES NO

HAVE YOU EVER EXPERIENCED AN ADVERSE REACTION DURING MEDICAL OR DENTAL TREATMENT? YES NO IF YES, DESCRIBE _____

LIST ALL MEDICATIONS YOU ARE NOW TAKING (PLEASE INCLUDE OVER-THE-COUNTER VITAMINS, HERBS, PAIN RELIEVERS AND ILLEGAL DRUGS)

AUTHORIZATION

I HAVE REVIEWED THE INFORMATION ON THIS QUESTIONNAIRE AND IT IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THIS INFORMATION WILL BE USED BY THE DENTIST TO HELP DETERMINE APPROPRIATE AND HEALTHFUL DENTAL TREATMENT. IF THERE IS ANY CHANGE IN MY MEDICAL STATUS, I WILL INFORM THE DENTIST.

I AUTHORIZE THE INSURANCE COMPANY INDICATED ON THIS FORM TO PAY TO THE DENTIST ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

I AUTHORIZE THE DENTIST TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE.

SIGNATURE OF RESPONSIBLE PARTY _____ DATE _____

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT, UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.