Welcome To AV DENTAL!

Tell us, about yourself

Please Print

Name:_____
Last First MI

I prefer to be called:_____

Please circle one on each group:

Male/Female Single/Married/Child/Other

Date of Birth: _____/_____/_____

Soc. Sec#:_____-_____-_____

Mailing Address: _____

City:_____ State:_____ Zip:_____

Home Phone_____Work Ph. _____

Email_____

Place of Employment_____

Name of Spouse or Guardian if patient is a minor:

_____Work Phone _____

Spouse/Guardian Employer:_____

Whom may we thank for referring you:_____

Primary Dental Insurance

Company Name:_____

Address:_____

_____

Phone: ( )_____-_____

Group# (Plan, Local or Policy #): _____

Insured's Name:_____Relation:_____

Insured's Birthday:_____/_____/_____

Insured's Soc. Sec#:_____-_____-_____

Are you allergic to any of the following?

Penicillin Yes / No Aspirin Yes / No

Bleach Yes / No Latex Yes / No

Please list any other known drug allergies: _____

_____

Who can we call in case of *Emergency?*

Name:_____Relation: _____

Home #:___-_____Work #:____-_____Ext.:_____

To avoid misunderstandings regarding dental insurance, we wish our patients to know that payment for all professional services provided, is the sole responsibility of the patient (or guardian, in case of minors) receiving such services. We do not accept insurance assignments without a predetermination, which normally takes around a month to receive from the insurance company. We will be glad to fill out claim forms and receipts that your insurance company might requests in order to issue a refund for services you have already paid.

Medical History

Are you currently under the care of a physician? Yes / No

Please explain:_____

Name of the Doctor _____ Phone_____

Please list any prescribed or over the counter drugs you are currently taking: _____

Have you ever been diagnosed / treated for any of the following medical conditions?

Heart Attack/Stroke	Yes / No
Heart Murmur	Yes / No
Rheumatic Fever	Yes / No
Mitral Valve Prolapse	Yes / No
Heart Surgery/Pacemaker	Yes / No
High/Low Blood Pressure	Yes / No
Congenital Heart Defect	Yes / No
Hemophilia/Abnormal Bleeding	Yes / No
Anemia	Yes / No
Blood Transfusions	Yes / No
Difficulty Breathing	Yes / No
Severe/Frequent Headaches	Yes / No
Sinus Problems	Yes / No
Epilepsy/Seizures/Fainting Spells	Yes / No
Tuberculosis	Yes / No
Diabetes	Yes / No
Cancer/Chemotherapy/Radiotherapy	Yes / No
Artificial Bones/Joints	Yes / No
HIV/AIDS	Yes / No
Kidney Problems	Yes / No
Hepatitis/Liver Problems	Yes / No
Ulcers/Colitis	Yes / No
Hospitalized last 2 Years	Yes / No

Please list any serious medical conditions you ever had, not listed above: _____

_____

Dental History

How will you describe, your dental health at present:
Good / Fair / Poor

Do you like the appearance of your smile? Yes / No

If not, Why? _____

Do your gums ever bleed? Yes / No

How many times a day, do you brush? _____ Floss? _____

Types of bristles: Hard / Medium / Soft

For Women: Are you pregnant? Yes / No Week# _____

Are you taking Birth Control Pills? Yes / No

Are you Nursing? Yes / No

Consent:

I certify that all the information above regarding my personal data and state of health is true. I understand that responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Signed: _____
Parent or Guardian if patient is a minor

Date: _____/_____/_____