TYLER CENTER FOR DENTAL HEALTH

we're so glad you're here!

TELL US ABOUT YOU

Today's Date: _____

Name: _____
First *Middle* *Last*

Mailing Address: _____ Birthdate: _____ / _____ / _____

_____ SSN# _____
City *State* *Zip*

Phone Cell: (___) _____ Work: (___)_____ Home: (___)_____

Email: _____ Are you interested in statements by email? Y or N

Employer: _____

Employers Address: _____

Do you have any dental concerns today? _____

In case of emergency contact? _____ Phone: _____

If you are completing this form for another person, what is your relationship to that person?

_____

How did you hear about our office? _____

INSURANCE

Do You have dental insurance? Y or N

Insurance Company: _____ Phone: (____)_____

ID Number: _____ Group Number: _____

Your relationship to insured: Self / Spouse / Child

Insured's Name: _____ Insured Date of Birth: _____

Insured'd Employer: _____ Insured SS# _____

FAMILY

Are you (Single/Married/Divorced/Widowed)?

Spouse's Name _____
First *Middle* *Last*

Spouse's Phone Number: _____

Other family members seen by us: _____

MEDICAL

Physicians Name: _____ Phone: (___)_____

Do you have dental insurance? Y or N Date of last visit: _____ / ____ / _____ What kind of Health are you in? good / fair / poor

Have you had any serious illness, operation, or been hospitalized in the past 5 years? _____

Are you taking any medicines, including non-prescription medicines? Y or N

_____

Have you had any metal rods, pins, or implants? Y or N Do you smoke or use tobacco in any form? Y or N

Women: are you taking birth control pills? Y or N Are you pregnant? Y or N Are you nursing? Y or N

Are you allergic to any of the following?

Aspirin Metal Penicillin Latex Codeine Sulfa drugs Acrylic Local Anesthetic _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Abnormal Bleeding/ Hemophilia
AIDS
Alcohol/Drug abuse
Anemia
Arthritis
Artificial Joints/Valves
Asthma
Blood Transfusion
Cancer
Chemotherapy
Cardiovascular Disease
Colitis
Congenial Heart Defect
Diabetes
Difficulty Breathing
Emphysema
Fainting Spells
Frequent Headaches
Glaucoma
Hay Fever
Hearing Aids
Heart Attack/ Surgery
Heart Murmur
Hepatitis
Herpes/Fever Blister/ Cold Sores
High Blood pressure
HIV
Kidney Problems
Liver Disease
Low Blood Pressure
Lupus
Mitral Valve Prolapse
Neurological Disease
Pacemaker
Psychiatric Problems
Radiation Treatment
Respiratory Problems/ Bronchitis
Rheumatic/ Scarlet Fever
Seizures
Sexually Transmitted Disease
Shingles
Sickle Cell Disease/Traits
Sinus Problems
Spleen Problems Tuberculosis (TB)
Ulcers
Venereal Disease

I certify that I have read and understood the above and that the information I have given today is correct to the best of my knowledge. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form. I also understand that it is my responsibility to inform this office of any changes in my medical status. If this office files with my insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to Tyler Center for Dental Health of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the release of any information, including the diagnosis and record of treatment or examination rendered, to my insurance company.

I have received a copy of this office's Notice of Privacy Practices (HIPAA) and understand that this information will be held in the strictest confidence.

Signature of Patient (or Guardian): _____

Signature of Doctor/Hygienist: _____

Date _____ Date _____