Seneca Park Dentistry, LLC

Patient Information

Patient Name: _____ Preferred Name: _____
Address: _____
Home Phone #: _____ Work Phone#: _____ Cell Phone #: _____
Date of Birth: _____ SSN#: _____ Driver's License# _____
Marital Status: Single Married Divorced Separated Other: _____ Sex: M or F
In case of Emergency Notify: _____
Reason for visit: _____ Referred By: _____
Has any member of your family been treated in this office? Yes or No

Person Responsible for Account Information

Same as above? Yes No (If no, please fill out information below)
Name: _____ Home Phone: _____
Address _____ Work Phone: _____
City and Zip code: _____ Date of Birth: _____
State: _____ SSN#: _____
Marital Status: Single Married Divorced Separated

Dental Insurance Information

	Primary	Secondary
Insured's Name:	_____	_____
Insured's Employer	_____	_____
Ins Co. Name:	_____	_____
Ins Co. Address:	_____	_____
	_____	_____

Group#: _____ ID#: _____ Provider Phone #: _____

Dental History

Do you have a specific dental problem?	Y or N
Do you have dental exams on a routine basis? Last visit? _____	Y or N
Do you think you have active decay or gum disease?	Y or N
Do you brush and floss on a routine basis?	Y or N
Do your gums ever bleed? When? _____ How often? _____	Y or N
Do you like your smile?	Y or N
Does food catch between your teeth?	Y or N
Do you ever have clicking, popping, or discomfort in the jaw joint?	Y or N
Do you brux or grind?	Y or N
Do you smoke or Chew?	Y or N
Any sores in your mouth?	Y or N

Any sensitivity to...Hot_____ Cold_____ Sweets_____ Biting_____
Date of full mouth x-rays? _____ Bitewings? _____ Pano? _____
Name of previous dentist: _____

Financial Agreement

Patients who carry Health Insurance should remember that professional services are rendered and charged to the patient and not to the Insurance Company. We request the courtesy of 24-hour advance cancellation or rescheduling of appointment to avoid incurring a missed appointment fee. This fee will vary depending on the amount of time set aside for your particular appointment.

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/ guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by my insurance.

_____ _____
Signature of Patient or Parent/Guardian Date

Seneca Park Dentistry, LLC

Patient Name:_____ **Date of Birth:**_____

Have you ever taken any of the group of drugs collectively referred to as "Fen-Phen?" These include combinations of Ionimin, Adipex, Fastin (Brand namses of Phentermine), Pondimin (Fenfluramine) and Redux (dexfenfluramine). YES or NO

MEDICAL HISTORY (Circle any of the following which you have had or have present)

Heart Murmur	Painful or Swollen Joints	Tiredness/ Lethargy
Mitral Valve Prolapse	Skin Disease	Untreated Mouth Sores
Blurred Vision	Kidney Disease/ Transplant	Psychiatric Therapy
Ringing Ears	Headaches	Bruise Easily
Nausea	Diabetes	Emphysema
Bleeding Problem/ Hemophilia	Thyroid Disease	Hay Fever
Anemia	Cancer or Tumor	Sinus Trouble
Circulatory Problems	Radiation Treatments	Asthma
High or Low Blood Pressure	History of Substance Abuse	Dizziness
Stroke	Alcohol	Sickle Cell Disease
Heart Attacks	Drugs	Glaucoma
Fainting Spells	Chronic Diarrhea	Cortisone Medication
Seizures	Unexplained Weight Loss	Traumatic Accidents
Shortness of Breath	Swollen Lymph Glands	Other: _____

ALLERGIES OR BAD REACTIONS TO:

Aspirin	Local Anesthetics	Tetracycline
Codeine	Valium	Latex Sensitivity
Erythromycin	Penicillin	Acrylic
Tylenol	Sulfa Drugs	Other: _____

INFECTIOUS DISEASES OR EXPOSURE TO SOMEONE WITH:

Rheumatic Fever**	Herpes I/II	Measles
Scarlet Fever	Venereal Diseases	Mumps
Hepatitis A (infectious)	AIDS/HIV	Chicken Pox
Hepatitis B (serum)	Epstein - Barr Virus	Tuberculosis
Hepatitis C	Mononucleosis	Other: _____

SURGERIES:

Artificial Joint**	Heart Surgery**	Cosmetic
Artificial Heart Valve**	Tonsils	Other: _____
Heart Pacemaker**	Adenoids	

Do you have any current health problems? Y N
Are you under physician care now? Y N
For what? _____
Are you currently taking any medication? Y N
If yes, what? _____
Have you been hospitalized recently? Y N
If yes, why? _____
Are there any physical and mental handicaps? Y N
If yes, what? _____

Are you pregnant? Y N
Trying to get pregnant? Y N
Nursing? Y N
Taking oral contraceptives? Y N
Current Physicians Name: _____
Address: _____
Phone #: _____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____ _____

Signature of Patient or Parent/ Guardian Date