Discovery Dental Group

Medical Alert For Office Use

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Thank you for visiting Discovery Dental Group. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name _____
LAST FIRST MIDDLE INITIAL NICKNAME

Address _____
STREET

_____
CITY STATE ZIP

Employer _____ Email _____

Birth date _____ Height _____ Weight _____

Phone: Home (____) _____ Social Security # _____

Work (____) _____ May we contact you at work? ❑ Yes ❑ No

Mobile(____) _____ ❑ Male ❑ Female

Emergency Contact: Name _____ Phone (____) _____

Insurance

Primary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Secondary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature _____ **Date** _____

If Patient is Under 18

Responsible Party _____ Relation to Patient _____

Address _____
STREET

_____
CITY STATE ZIP

Telephone (____) _____

Other Information

How did you hear about us? _____

What is the reason for today's visit? _____

Is there anything about your smile you would like to change? _____

When was your last dental examination? _____

Why did you leave your last dentist? _____

What did you like *most* about your last dentist? _____

Medical History and Information

Conditions

Y	N	
❑	❑	Abnormal Bleeding
❑	❑	Alcohol Abuse
❑	❑	Allergies
❑	❑	Anemia
❑	❑	Angina Pectoris
❑	❑	Arthritis
❑	❑	Artificial Heart Valve
❑	❑	Asthma
❑	❑	Augmentation
❑	❑	Blood Transfusion
❑	❑	Blood Thinners
❑	❑	Cancer
❑	❑	Chemotherapy
❑	❑	Colitis
❑	❑	Congenital Heart Defect
❑	❑	Diabetes
❑	❑	Difficulty Breathing
❑	❑	Drug Abuse
❑	❑	Emphysema
❑	❑	Epilepsy
❑	❑	Facial Surgery
❑	❑	Fainting Spells
❑	❑	Fever Blisters
❑	❑	Frequent Headaches
❑	❑	Glaucoma
❑	❑	HIV+ Aids
❑	❑	Heart Murmur
❑	❑	Heart Surgery
❑	❑	Hemophilia
❑	❑	Hepatitis A
❑	❑	Hepatitis B
❑	❑	Hepatitis C
❑	❑	High Blood Pressure
❑	❑	Joint Replacement
❑	❑	Kidney Problems
❑	❑	Liver Disease
❑	❑	Low Blood Pressure
❑	❑	Mitral Valve Prolapse
❑	❑	Osteoporosis
❑	❑	Pace Maker
❑	❑	Psychiatric Problems
❑	❑	Radiation Therapy
❑	❑	Rheumatic Fever
❑	❑	Seizures
❑	❑	Sexually Transmitted Disease
❑	❑	Shingles
❑	❑	Sickle Cell Disease
❑	❑	Sinus Problems
❑	❑	Stroke
❑	❑	Thyroid Problems
❑	❑	Tuberculosis
❑	❑	Ulcers

Allergies

Y	N	
❑	❑	Aspirin
❑	❑	Codeine
❑	❑	Dental Anesthetics
❑	❑	Erythromycin
❑	❑	Latex
❑	❑	Metals
❑	❑	Penicillin
❑	❑	Sulfa
❑	❑	Tetracycline
❑	❑	Food Allergies (i.e., milk, nuts)

Other _____

Y	N	
❑	❑	Do you Smoke Or use Tobacco?

If Female

Y	N	
❑	❑	Are you taking Birth Control Pills?
❑	❑	Are you pregnant? If yes, # of weeks_____
❑	❑	Are you nursing?

Please list all medications
You are currently taking: _____

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility and I agree to pay collection and legal fees if any delinquent balance is placed with an agency or attorney for collection or suit.

_____ _____

PATIENTS SIGNATURE DATE

If patient is a child or requires a guardian:

_____ _____

PARENT/GUARDIAN SIGNATURE DATE