Welcome to Acadian Dental

Patient Information

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name _____ Date_____ SS#_____
First Middle Initial Last

Address_____ City_____ State_____ Zip_____

O Female O Male Birthdate_____ Email_____

Home Phone (_____) _____ Cell Phone (_____)_____ Work Phone (_____)_____

Do you prefer to receive calls at OHome OWork O Cell O No Preference

O Married OWidowed OSingle OSeperated ODivorced

Patient Employer/School _____ Occupation_____

Employer/School Address _____ City_____ St_____Zip_____

Spouse or parent's name _____ Employer_____ Work Phone(___)_____

Whom may we thank for referring you to us_____

Person to contact in case of emergency_____ Phone(_____)_____

Responsible Party

Name of person responsible for this account_____

Relationship to patient_____ Phone(_____)_____

Address_____ City_____ State_____ Zip_____

Name of employer_____ Work Phone(___)_____

Insurance Information

Name of Insured_____ Relationship to Patient_____

Birthdate_____ Social Security #_____ Date Employed_____

Name of employer_____ Work Phone(___)_____

Insurance Co._____ Group#_____ Employer#_____

DO YOU HAVE ADDITIONAL INSURANCE OYes ONo IF YES PLEASE COMPLETE THE FOLLOWING:

Name of Insured_____ Relationship to Patient_____

Birthdate_____ Social Security #_____ Date Employed_____

Name of employer_____ Work Phone(___)_____

Insurance Co._____ Group#_____ Employer#_____

*****Payment is due at time of service. The estimate we give you is an estimate only, any portion the insurance does not pay is your responsibility. I understand and agree with the above statement..***

Signature & Date:_____

MEDICAL HISTORY
For
New Patient

Birth Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? O Yes Please explain:_____

Have you ever

been hospitalized? O Yes Please explain:_____

had a major operation? O Yes Please explain:_____

had a serious head/neck Injury? O Yes Please explain:_____

Are you taking any medications? O Yes Please explain:_____

Do you take or have you taken Phen-Fen/Redux? O Yes Please explain:_____

Are you on a special diet? O Yes Please explain:_____

Do you use tobacco? O Yes Please explain:_____

Do you use controlled substances? O Yes Please explain:_____

WOMEN ONLY:

Are you:

Pregnant/Trying to get pregnant? O Yes Taking oral contraceptives? O Yes Nursing? O Yes

Are you allergic to any of the following:

O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Local Anesthetics

O Other If yes, please explain: _____

Please check if you have, or have had any of the following:

O AIDS/HIV Positive	O Cortisone Medicine	O Hemophilia	O Renal Dialysis
O Alzheimer's	O Diabetes	O Hepatitis A	O Rheumatic Fever
O Anaphylaxis	O Drug Addiction	O Hepatitis B or C	O Rheumatism
O Anemia	O Easily Winded	O Herpes	O Scarlet Fever
O Angina	O Emphysema	O High Blood Pressure	O Shingles
O Arthritis/Gout	O Epilepsy or Seizures	O Hives or Rash	O Sickle Cell Disease
O Artificial Heart Valve	O Excessive Bleeding	O Hypoglycemia	O Sinus Trouble
O Artificial Joint	O Excessive Thirst	O Irregular Heartbeat	O Spina Bifida
O Asthma	O Fainting Spells/Dizziness	O Kidney Problems	O Stomach/Intestinal Disease
O Blood Disease	O Frequent Cough	O Leukemia	O Stroke
O Blood Transfusion	O Frequent Diarrhea	O Liver Disease	O Swelling of Limbs
O Breathing Problem	O Frequent Headaches	O Low Blood Pressure	O Thyroid Disease
O Bruise Easily	O Genital Herpes	O Lung Disease	O Tonsillitis
O Cancer	O Glaucoma	O Mitral Valve Prolapse	O Tuberculosis
O Chemotherapy	O Hay Fever	O Pain in Jaw Joints	O Tumors or Growths
O Chest Pains	O Heart Attack/Failure	O Parathyroid Disease	O Ulcers
O Cold Sores/Fever Blisters	O Heart Murmur	O Psychiatric Care	O Venereal Disease
O Congenital Heart Disorder	O Heart Pace Maker	O Radiation Treatments	O Yellow Jaundice
O Convulsions	O Heart Trouble/Disease	O Recent Weight Loss	

Have you ever had any serious illness not listed above? Please Explain _____

To the best of the knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changed in medical status.

Signature of Patient, Parent, or Guardian _____ Date:_____