TENDER CARE FAMILY DENTISTRY

PATIENT INFORMATION

Patient's Name: _____
Last First

Address: _____

_____
City State Zip code

Date of Birth: _____/_____/_____ **Age:** _____ **Sex:** M F

Home no.: _____ **Cell no.:** _____

Emergency contact: _____ **Relation:** _____

How Did You Hear About Us?

- ❑ Friend/Relative
- ❑ Flyer/Mail
- ❑ Internet
- ❑ Other _____
- ❑ Sign
- ❑ Insurance
- ❑ Employee

Are you currently under the care of a physician? Y N

Physician Name: _____**Office no.:** _____

Please read and initial our office policies below:

_____ We recognize that patients have the Rights of Privacy concerning their personal health information. We make every effort to protect and reserve patient records in a manner that secures this information. By signing the acknowledgement below, you are confirming that you have read our Privacy Practices. If for any reason, you would like to have your record transferred, there will be a fee of $25.

_____ Our practice is committed to provide the best treatment possible to our patients and we charge what are Usual and Customary rates for our area. We ask that each patient pay their deductible and their estimated patient portion at the time services are rendered. If, for any reason, your insurance company does not pay the estimated amount within 60 days, it becomes your financial responsibility.

_____ I understand radiographs may be necessary to properly complete my examination. I give Tender Care Family Dentistry permission to take any radiographs deemed necessary.

Health History:

	Y	N		Y	N		Y	N
Alzheimer's			Emphysema			Liver Problems		
Artificial heart valve			Epilepsy			Low BP		
AIDS/HIV			Fainting			Memory issues		
Anemia			Glaucoma			Pacemaker		
Arthritis			Heart attack			Osteoporosis		
Asthma			Heart surgery			Sinus trouble		
Autoimmune disease			Heart problems			Stroke		
Bleeding problems			Hepatitis			Thyroid issues		
Cancer			High BP			TMJ/TMD		
Chemo/rad therapy			Jaundice			Tobacco use		
Diabetes			Joint replacement			Tuberculosis		
Dementia			Kidney disease			V.D.		

Do you have any allergies (penicillin, codeine, sulfa, latex)? Y N

_____

Are you taking any medications at this time? Y N

_____

To my knowledge, all information provided has been answered completely and accurately. I will inform my dentist of any changes in my health and/or medications.

Patient Signature: _____ Date: _____

FOR OFFICE USE ONLY:

DR. SIGNATURE: _____ DATE: _____

DR. SIGNATURE: _____ DATE: _____

DR. SIGNATURE: _____ DATE: _____