PATIENT INFORMATION

Date: _____

Please print:

Patient Information (CONFIDENTIAL)

Name_____Home #:_____Cell#:_____

If a child, Parent or Guardian Name_____

Address_____City_____State_____Zip Code_____

Date of Birth_____ Sex: ❑M ❑F Soc. Sec. No_____

Driver's License #: _____

Check appropriate box: ❑Minor ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated

Patient's Employer/School_____Work Phone_____

Email Address_____ Emergency Contact_____( ) -_____

Whom may we thank for referring you?_____

Reason for Visit?_____

Responsible Party (Ex: Parents, Spouse, Caregiver, Nursing home, P.O.A, etc.)

Name of person responsible for this account_____

Relationship to Patient _____Home Phone_____

Address_____

Soc. Sec. No._____ Birthdate_____

Employer_____Work phone_____

Is this person currently a patient in our office? ❑Yes ❑No

Insurance Information:

Name of Insured _____ Relationship to Patient_____

Subscriber's Birthdate_____Soc. Sec. No._____

Name of Employer _____Work Phone_____

Name of Insurance Co. _____Group No._____

Ins. Co. Address_____City_____State_____Zip code_____

Type of Insurance: Medical ☐ Dental ☐ Medicare ☐ Medicaid ☐

Do you have additional insurance? ❑Yes ❑No If yes complete the following:

Name of Insured _____ Relationship to Patient_____

Subscriber's Birthdate_____Soc. Sec. No._____

Name of Employer _____Work Phone_____

Name of Dental Insurance Co. _____Group No._____

Ins. Co. Address_____City_____State_____Zip code_____

Type of Insurance: Medical ☐ Dental ☐ Medicare ☐ Medicaid ☐

Medical History:

	Yes	No
1) Are you under medical treatment now?	❑	❑
2) Have you ever been hospitalized for any surgical operations or serious illness?	❑	❑
3) Are you taking any medication(s) **including non-prescription** medications?	❑	❑

If yes, please list **all** medications you are currently taking:

_____

_____

_____

Circle if you have ever taken:

Aredia	Zometa	Fosamax
Actonel	Boniva	Xgeva

	Yes	No
4) Do you use tobacco?	❑	❑
5) Do you use alcohol, cocaine or other drugs?	❑	❑
6) Do you take an aspirin daily? ____mg	❑	❑
7) Are you allergic to any of the following:		
Local anesthetics (ex. Novocain)	❑	❑
Penicillin or other antibiotics	❑	❑
Sulfa drugs	❑	❑
Barbiturates	❑	❑
Sedatives	❑	❑
Iodine	❑	❑
Aspirin	❑	❑
Other	❑	❑
_____		
8) Does your jaw make noise or click when you open & close?	❑	❑
9) Do you ever have trouble opening widely?	❑	❑
10) Do your jaws bother you at night?	❑	❑
11) Do people complain about you snoring?	❑	❑
	❑	❑

Do you suffer from any of the following?

	Yes	No
Diabetes	❑	❑
High Blood Pressure	❑	❑
Heart attack	❑	❑
Low blood pressure	❑	❑
Heart disease	❑	❑
Cardiac pacemaker	❑	❑
Heart Murmur	❑	❑
Rheumatic Fever	❑	❑
Fainting	❑	❑
Asthma	❑	❑
Epilepsy/Convulsions	❑	❑
Leukemia	❑	❑
Kidney Diseases	❑	❑
HIV/AIDS	❑	❑
Anemia	❑	❑
Emphysema	❑	❑
Cancer	❑	❑
Hepatitis	❑	❑
Liver Disease	❑	❑
Joint Replacement	❑	❑
Stroke	❑	❑
Tuberculosis	❑	❑
Seizures	❑	❑
Herpes	❑	❑
Mitral Valve Prolapse	❑	❑
Abnormal Bleeding	❑	❑
Frequent Headaches	❑	❑
Ulcers/Colitis	❑	❑
Persistent Cough	❑	❑
Venereal Disease	❑	❑
Psychiatric Treatment	❑	❑
TMJ Disorder	❑	❑

Please list any others:

_____

_____

Name of Primary Medical Physician_____Phone:_____

Date of Last Medical Exam_____

Has there been any significant change in your health within the past five years which required you to be treated by a physician or to be hospitalized?_____

Please Explain _____

_____

Additional Medical History:

(Please circle to answer)

1)	Have your ever received Chemotherapy?	YES	NO
2)	Have you ever received radiation therapy?	YES	NO
3)	Have you ever been tested for HIV?	YES	NO
	If so, what were your test results at that time?	+	--
4)	Have you ever been tested for hepatitis?	YES	NO
	If so, what were the results at that time?	+	--
5)	Have you been tested recently for tuberculosis?	YES	NO
	If so, what were the results at that time?	+	--
	If so, was a chest x-ray taken at that time?	YES	NO
6)	Could you be pregnant	YES	NO

Dental History:

(Please circle to answer)

1)	Are your teeth sensitive to hot, cold, sweet or sour liquid/food?	YES	NO
2)	Do you feel pain in any of your teeth?	YES	NO
3)	Have you ever had difficult extractions in the past?	YES	NO
4)	Have you ever had prolonged bleeding following an extraction?	YES	NO
5)	Are you currently wearing dentures?	YES	NO
	Age of existing dentures:_____ years old		
6)	Date of last x-ray series is _____		
	How many were taken?_____		

Authorization and Release

I consent to be a patient at Fort Wayne Prosthodontics, Inc. and confirm 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 the office of any changes in my medical status. I authorize the staff to perform the necessary services I may need. I agree to pay for services which I and the doctor agree to have rendered at the time of service. I understand that any insurance benefits will be assigned to me and that I am responsible to the doctor for payment of services. I authorize the release of any information necessary to process an insurance claim.

During the course of treatment, I may undergo procedures in all phases of dentistry, including periodontics (gum treatment), oral surgery, fixed and removable prosthodontics (crown, bridges, and dentures), Implant dentistry, restorative dentistry (such as fillings), oral pathology, cleanings, and radiography. I do voluntarily assume any and all possible risks, including the risk of substantial harm, risk of infection including COVID, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved.

I understand that my treatment plan may change at any time, and that I am welcome to ask questions about any aspect of my dental treatment and will request information if I am confused. I am responsible for clarifying any aspects of my treatment that I am unsure about. No guarantees can be made of treatment outcomes, restoration longevity, or prognosis. I understand that any branch of medicine, including prosthodontics can involve unanticipated results.

Signature:_____Date:_____