UPTOWN PARK DENTAL PRACTICE LLC

We're glad you're here!

Patient Information Date: _____

Name: First: _____ Middle: _____ Last: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Driver's License #: _____ SSN/ID#: _____ Date of Birth: _____ Sex: M / F

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Marital Status: Single / Married / Widowed / Separated / Divorced

Have you or any member of your family been seen by us before? Yes / No

If yes, which family member(s)? _____

Patient's Employer: _____ Occupation/Position: _____

Emergency Contact: _____ Phone: _____

If patient is a Student, name of School/College: _____ City: _____ State: _____

How did you hear about us?

Mail/Valpak Website (name) _____ Radio (station) _____ Insurance Co (name) _____

Mail/Postcard Magazine (name) _____ Television (station) _____ Referral (name) _____

If the person responsible for this patient's account is different from the patient, or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section titled "Insurance Information".

Name of Responsible Party: _____ Relationship to Patient: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Sex: M / F Age: _____ Date of Birth: _____ Home Phone: _____ Work Phone: _____

SSN/ID#: _____ Marital Status: Single / Married / Widowed / Separated / Divorced

Employer: _____ Occupation/Position: _____

Insurance Information

Primary Dental Insurance

Policy Holder's Name: _____ Relationship to Patient: _____ SSN/ID#: _____ DOB: _____

Employer: _____ Insurance Co: _____ Group #: _____

Secondary Dental Insurance

Policy Holder's Name: _____ Relationship to Patient: _____ SSN/ID#: _____ DOB: _____

Employer: _____ Insurance Co: _____ Group #: _____

FOR OFFICE USE:

_____

_____

_____

_____

HEALTH HISTORY PATIENT NAME: DATE:

Answers to the following questions are for our records only and will be considered confidential.

Please circle, Yes or No, to indicate if you have had any of the following:

Heart Disease or Attack	Yes	No
Angina Pectoris	Yes	No
Heart Problems	Yes	No
Liver Disease	Yes	No
High Blood Pressure	Yes	No
Heart Murmur	Yes	No
Rheumatic Fever	Yes	No
Psychiatric Treatment	Yes	No
Sickle Cell Disease	Yes	No
Sinus Trouble	Yes	No
Artificial Joints*	Yes	No
Thyroid Disease	Yes	No
Anemia	Yes	No
Blood Transfusion	Yes	No
Mitral Valve Prolapse*	Yes	No
Hives or Skin Rash	Yes	No
Scarlet Fever	Yes	No
Shortness of Breath	Yes	No
Ulcers	Yes	No
Mental Impairment	Yes	No
Emphysema	Yes	No
Fainting or Dizzy Spells	Yes	No
Epilepsy or Seizures	Yes	No
Persistent Cough	Yes	No
Tuberculosis (TB)	Yes	No
Asthma	Yes	No

Congenital Heart Disease*	Yes	No
Hepatitis A (Infectious)	Yes	No
Hepatitis B (Serum)	Yes	No
Hepatitis C or Other	Yes	No
Heart Pacemaker	Yes	No
Stroke	Yes	No
Drug Addiction	Yes	No
Cold Sores	Yes	No
COPD**	Yes	No
Alcoholism	Yes	No
Herpes	Yes	No
Glaucoma	Yes	No
Steroid Treatment*	Yes	No
Arthritis	Yes	No
Birth Defects	Yes	No
HIV Positive, ARC, AIDS	Yes	No
Hay Fever	Yes	No
Use of Tobacco Products	Yes	No
Bruise Easily	Yes	No
Jaundice	Yes	No
Kidney Trouble	Yes	No
Human Papilloma Virus/HPV	Yes	No
Hemophilia	Yes	No
Diabetes	Yes	No
Chemotherapy/Radiation	Yes	No
Cancer, type:	Yes	No

* Antibiotic pre-medication may be required prior to your appointment.
** Chronic Obstructive Pulmonary Disorder

Please list any changes to your health history since your last appointment:

MEDICATIONS (Please list any medications you are currently taking):

_____

_____

Are you currently taking Fosamax or any bone density medication? Yes / No
Are you currently taking any blood thinning medication? Yes / No

Name of your pharmacy: _____

ALLERGIES (Please Circle):
Aspirin Local Anesthetic Barbiturates Penicillin Codeine Sulfa Iodine Metals Latex Other: _____

Do you have existing dentures? Yes / No Age? ____ (yrs) Upper / Lower
Do you have an existing partial? Yes / No Age? ____ (yrs) Upper / Lower

Date of last physical examination: _____
Physician's name/address: _____

Date of last dental x-rays: _____
Previous dentist's name/address: _____

What is the primary reason for your visit today? _____
Are you having pain or discomfort at this time? Yes / No Do you clench or grind your teeth? Yes / No
Do you have any sores, lumps or growths in or near your mouth? Yes / No
Have you ever had any excessive bleeding requiring special treatment? Yes / No
Do you feel nervous about having dental treatment? Yes / No
Have you ever had a bad experience at a dental office? (please describe) Yes / No _____
Is there anything you would like to change about the way your smile looks? Straighter / Whiter / Other _____
Do you currently have any of the following? Swelling / Bleeding gums / Loose teeth / Bad breath
Is there anything related to your medical or dental history that you have not indicated above? Yes / No
If yes, please explain: _____

WOMEN: Are you taking oral contraceptives? Yes / No Are you currently breast feeding? Yes / No
Are you pregnant now? Yes / No If yes, what is your due date? _____

_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been answered accurately. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group any insurance benefits otherwise payable to me. I understand my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment for all services provided to me or my dependents or otherwise rendered on my behalf.

X _____ **Date:** _____
Patient Signature (or, if applicable, Parent or Guardian Signature)

Reviewed by: (Doctor) _____ Date: _____ B.P. _____