

Welcome to Power Road Dental Care

Patient's Name _____
Married__ Single__ Divorced__ Widowed__ Separated__
Sex: M__ F__ Birthdate _____ Social Security # _____
Address _____
City/State/Zip _____
Home Ph # _____ Work Ph # _____ Cell Ph # _____
E-mail Address _____
Employer _____
Business Address _____
Occupation _____
College Student? Yes/ No Full or Part Time? College/University _____

Primary Dental Insurance Information

Subscriber's name _____
Subscriber's address _____
Subscriber's SS# _____ Birthday _____
Relationship to patient _____
Subscriber's employer _____
Business address and phone _____
Insurance Company _____ Phone # _____
ID# _____ Group # _____

Secondary Dental Insurance Information

Subscriber's name _____
Subscriber's address _____
Subscriber's SS# _____ Birthday _____
Relationship to patient _____
Subscriber's employer _____
Business address and phone _____
Insurance Company _____ Phone # _____
ID# _____ Group # _____

Dental History

Reason for today's visit _____ Last dental visit _____
Date of last x-rays _____ cleaning _____
Check if you have or have ever had any of the following:
Bad breath__ Bleeding gums__ Clicking or popping of jaw__ Trauma to head or neck__
Sensitivity to: Sweets__ Hot__ Cold__ Biting pressures__
Sores or growths in your mouth__ Do you grind your teeth? Yes No
Are you happy with the appearance of your teeth? Yes No

We expect payment in full at each appointment. For your convenience we offer the following methods of payment, please circle the option you prefer.

Cash Visa/MC/Discover/Am. Express Check Driver's license # _____

History

Physician's Name: _____ Phone # _____

Are you under medical treatment now? Yes No

If so, what for? _____

Have you been hospitalized in the last 5 years? Yes No

If so, what for? _____

Have you ever had a blood transfusion? Yes No When? _____

Women - If you are pregnant, when is your due date? _____

Indicate which of the following you have had or have at present. Circle "yes" or "no"

to each item.

Heart Murmur	Yes	No	Kidney Problems	Yes	No
Heart Problems	Yes	No	Liver Problems	Yes	No
Rheumatic Fever	Yes	No	Hepatitis	Yes	No
Chest Pain	Yes	No	Lung Problems	Yes	No
Bleeding Problems	Yes	No	Sinus Problems	Yes	No
Hi/Lo Blood Pressure	Yes	No	Stroke	Yes	No
Diabetes	Yes	No	Nervous Problems	Yes	No
Ulcers	Yes	No	Cancer	Yes	No
Thyroid	Yes	No	Radiation Treatment	Yes	No
Asthma	Yes	No	Arthritis	Yes	No
Artificial valves,limbs,joints	Yes	No	Allergies/Hay Fever	Yes	No
Implants	Yes	No	Hives	Yes	No
Epilepsy	Yes	No	HIV/AIDS	Yes	No
Fainting	Yes	No	Anemia	Yes	No
Pacemaker	Yes	No			

List all allergies: _____

(Penicillin, Codeine, Latex, Any Metals)

List all medications, including vitamins and herbal supplements, you take: _____

Is there anything you want us to know? _____

In case of an emergency who should be notified? Please give name and phone number.

Relative _____

Non-Relative _____

Who may we thank for referring you to our office?

Internet: _____ Mailer: _____ Friend/Relative (Name): _____ Other: _____

Authorization Release

I certify that I have read and answered the above questions to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health and that it is my responsibility to inform this office of any changes in my medical status. 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 payers and/or health practitioners. I hereby give my consent for any preventative and/or restorative treatment that the dentist and I have deemed necessary. I authorize and request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I further agree to pay all finance charges, collection costs, attorney fees, and any other cost that may be incurred to enforce collection of any amount outstanding.

_____ Date _____

Signature of patient, parent or guardian