Alliance DENTAL CARE

Welcomes You!

Today's Date:_____

Name:_____ Birthdate: _____

If child, Parent or Guardian names: _____

Address: _____CIty: _____ Zipcode:_____

Cell Phone: _____Home/Work Phone:: _____

Can you send/receive text messages on your cell phone: yes____ no_____

Email Address _____

Emergency contact: _____Phone Number: _____

Whom may we thank for referring you to us: _____ Phone #:_____

What other ways have you heard about us: ____ Location _____Mailer_____ Facebook_____Friend_____

____ Instagram _____ Employer _____ Website

MEDICAL HISTORY

Name of Physician: _____

Physician phone #: _____

Current Health: ____ good _____ fair____ poor

Are you currently being treated?_____

_____

Are you taking any non prescription medications?

____no _____yes

Are you taking any prescription drugs?

____no _____yes

DENTAL HISTORY

How may we help today? _____

Are you in pain today? _____

Current Dental Health: ___good ___ fair___ poor

Please circle if you are allergic or had reactions to any of the following:

PENICILLIN / ANTIBIOTICS

DENTAL ANESTHETICS

ASPRIN

ERYTHROMYCIN

TETRACYCLINE

IODINE

CODEINE

LATEX

SULFA DRUGS

METALS (MERCURY)

PLEASE COMPLETE REVERSE SIDE OF THIS FORM ALSO

Date of last dental care_____ Last dental x-rays_____

Please check( ) if you have had trouble with any of the following:

☐ Bad Breath
☐ Bleeding Gums
☐ Clicking or Popping Jaw
☐ Food collection between teeth
☐ Grinding Teeth
☐ Loose Teeth or Broken Fillings
☐ Periodontal Treatment
☐ Sensitivity to Cold
☐ Sensitivity to Heat
☐ Sensitivity to Sweets
☐ Sensitivity when Biting
☐ Sores or growths in your mouth

How often do you floss?_____ How often do you brush?_____

Have you ever experienced an adverse reaction during or in conjunction with a dental procedure? If yes, explain_____

Previous hospitalizations, illnesses, or operations (please describe, and give approximate date)_____

_____

Have you ever had a blood transfusion? 0 Yes O No If yes, please give approximate date_____

Women: Are you pregnant? 0 Yes O No Nursing? 0 Yes O No Taking birth control pills? 0 Yes 0 No

Please check ( ) if you have had any of the following

0 AIDS	0 Cortisone Treatments	0 Hepatitis	0 Rheumatic Fever
0 Anemia	0 Cough, Persistent	0 High Blood Pressure	0 Scarlet Fever
0 Arthritis, Rheumatism	0 Cough up Blood	0 HIV Positive	0 Shortness of Breath
0 Artificial Heart Valves	0 Diabetes	0 Jaw Pain	0 Skin Rash
0 Artificial Joints	0 Epilepsy	0 Kidney Disease	0 Stroke
0 Asthma	0 Fainting	0 Liver Disease	0 Swelling of Feet or Ankles
0 Back Problems	0 Glaucoma	0 Mitral Valve Prolapse	0 Thyroid Problems
0 Blood Disease	0 Headaches	0 Nervous Problems	0 Tobacco Habit
0 Cancer	0 Heart Murmur	0 Pacemaker	0 Tonsillitis
0 Chemical Dependency	0 Heart Problems	0 Psychiatric Care	0 Tuberculosis
0 Chemotherapy	Describe:_____	0 Radiation Treatment	0 Ulcer
0 Circulatory Problems	0 Hemophilia	0 Respiratory Disease	0 Venereal Disease

Please list any medications, both prescription and non-prescription, you are currently taking _____

_____

I have reviewed this questionnaire and answered its question accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment, and I agree to notify the dentist if any change in my health status should occur. In order to make our dental care more affordable for all our members, appointments are limited and patients need to keep scheduled appointments.

☐ I understand that I must give a full 24 hour notice if an appointment needs to be cancelled or rescheduled. I agree to the Alliance Dental Care Policy that missed appointments, cancelled, or rescheduled appointments with less than 24 hours will incur a $50 fee on the patient account, due prior to patient being seen again.

☐ I understand that full payment is always due on the day of the service.

☐ I understand that if a patient elects to cancel membership, there is a 36 month waiting period before being eligible to renew membership again. Maintaining memberships helps us keep our prices low.

Patient SIgnature:_____ Date:_____