EMMANUEL
Dental & Fastbraces

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Today's Date:_____ Email Address: _____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

GETTING TO KNOW YOU

NAME:_____
LAST FIRST MIDDLE

Maritial Status: ☐ Married ☐ Widowed ☐Single ☐Minor ☐ Separated ☐Divorced ☐Partnered for _____ years

Birthdate: ____/____/_____ Age:_____ SSN:_____

Home Address:_____

City:_____State:_____Zip:_____

Home Phone:(___)_____ Business Phone: (___)_____

Cell Phone:(___)_____

I perfer to be contacted by: ☐ Home Phone ☐ Cell Phone ☐ Text ☐ Email

EMPLOYER:_____

Work Address:_____Occupation:_____

★Please tell us how you heard about our office: □ Internet □ Flyers
□ Mailer □ Other: _____
□ Patient /Friends/Family(Whom may we thank): _____

Spouse Information: Name:_____ DOB: _____

Employer: _____ Position:_____

Work Phone: _____ SSN: _____

Emergency Contact Name : _____Relationship:_____

Home Phone: _____ Work/Cell Phone: _____

Person Responsible for Account (if other than yourself)

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Employer: _____ SSN:_____

INSURANCE INFORMATION

Primary Dental Insurance: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address:_____

_____

Insurance Co. Phone: _____

Group #: _____ Member #: _____

Insured's Name: _____

Relation to the insured: _____

Insured's Birthdate: _____/_____/_____

Insured's SSN: _____

Insured's Employer:_____

Secondary Dental Insurance: ☐ Yes ☐ No

ACKNOWLEDGEMENT

I certify that I (or my dependent) have insurance coverage with the above named insurance company (companies) and assign directly to Emmanuel Dental all insurance benefits. I understand that I am financially responsible for all charges: any deductible amount, Co-insurance, or any balance not paid for by my insurance company (if I may have one). I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party
Signature: _____

Please fill in completely:

DENTAL HISTORY

Reason for Today's Visit: _____

Former Dentist's Name: _____

Date of last dental visit: _____

Date of last dental X-Ray: _____

MEDICAL HISTORY

Your Physician's Name: _____

Phone Number: _____ Date of Last Visit: _____

Is there any Medical or Dental information you feel we should know about?

☐ Yes, please explain_____ ☐ No

Please mark "YES" or "NO" indicating if you have or have had any of the following:

Bad Breath	☐ YES	☐NO	AIDS/HIV	☐ YES	☐NO	Headaches	☐ YES	☐NO
Bleeding gums	☐ YES	☐NO	Anemia	☐ YES	☐NO	Heart Murmur	☐ YES	☐NO
Blisters on lips or mouth	☐ YES	☐NO	Arthritis, Rheumatism	☐ YES	☐NO	Heart Problems	☐ YES	☐NO
Burning sensation on tongue	☐ YES	☐NO	Artificial Heart Valves	☐ YES	☐NO	Hepatitis Type____	☐ YES	☐NO
Chew on one side of the mouth	☐ YES	☐NO	Artificial Joints	☐ YES	☐NO	Herpes	☐ YES	☐NO
Cigarette, pipe or cigar smoking	☐ YES	☐NO	Asthma	☐ YES	☐NO	High Blood Pressure	☐ YES	☐NO
Clicking or poping jaw	☐ YES	☐NO	Back Problems	☐ YES	☐NO	Jaundice	☐ YES	☐NO
Food Collection between your teeth	☐ YES	☐NO	Bleeding abnormally, w/extractions or surgery	☐ YES	☐NO	Jaw Pain	☐ YES	☐NO
Dry mouth	☐ YES	☐NO	Blood Disease	☐ YES	☐NO	Kidney Disease	☐ YES	☐NO
Earaches	☐ YES	☐NO	Cancer	☐ YES	☐NO	Liver Disease	☐ YES	☐NO
Grinding teeth	☐ YES	☐NO	Chemical Dependency	☐ YES	☐NO	Low Blood Pressure	☐ YES	☐NO
Gums swollen or tender	☐ YES	☐NO	Circulatory Problems	☐ YES	☐NO	Mitral Valve Prolapse	☐ YES	☐NO
Jaw pain or tiredness	☐ YES	☐NO	Congenital Heart Lesions	☐ YES	☐NO	Nervous Problems	☐ YES	☐NO
Lip or cheek biting	☐ YES	☐NO	Cortisone Treatment	☐ YES	☐NO	Pacemaker	☐ YES	☐NO
Loose teeth or broken fillings	☐ YES	☐NO	Cough, persistent or bloody	☐ YES	☐NO	Psychiatric Care	☐ YES	☐NO
Mouth breathing	☐ YES	☐NO	Diabetes	☐ YES	☐NO	Radiation Treatment	☐ YES	☐NO
Mouth pain when brushing	☐ YES	☐NO	Emphysema	☐ YES	☐NO	Respiratory Disease	☐ YES	☐NO
Orthodontic treatment (braces)	☐ YES	☐NO	Epilepsy	☐ YES	☐NO	Scarlet Fever	☐ YES	☐NO
Periodontal treatment	☐ YES	☐NO	Fainting or dizziness	☐ YES	☐NO	Shortness of Breath	☐ YES	☐NO
Sores or growth in your mouth	☐ YES	☐NO	Glaucoma	☐ YES	☐NO	Sinus Trouble	☐ YES	☐NO
Sensitivity to (if yes, please circle): cold, heat, sweets, or when chewing	☐ YES	☐NO	Do you wear contact lenses?	☐ YES	☐ No			
Do you regularly brush?	☐ YES	☐NO	Women: Are you pregnant?	☐ YES	☐ No	Due date: _____		
Do you regularly use floss?	☐ YES	☐NO	Are you nursing?	☐ YES	☐ No			

MEDICATIONS

Please list medications you are currently taking:

_____

_____

Pharmacy: _____Phone #: _____

ALLERGIES

☐ Asprin	☐ Local Anesthetic
☐ Barbiturates (Sleeping Pills)	☐ Latex
☐ Codeine	☐Penicillin
☐ Erythromycin	☐ Sulfa
☐ Iodine	☐ Other_____

Dr. Pramod Thomas Date

AUTHORIZATION AND CONSENT

I confirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in strictest confidence and it is my responsiblilty to inform the office of any changes. I hereby authorize the Doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of my dental needs. I aslo authorize the Doctor to perform dental treatment, medication, and therapy that may be indicated. I also understand that all dental procedures and the use of anesthetic agents carry a certain risk.

CONSENT(if child or minor):_____I hereby authorize the necessary dental treatment to be performed for the child named above.

Name: _____

Signature: _____Date: _____