



St. Francis Dental Care

Family Dentistry

Welcome to St. Francis Dental Care, P.A.

Patient Information

Date _____

Social Security # _____

Full Name _____

Address _____

City _____ State ____ Zip _____

E-Mail _____

Sex: M F Age _____ Birthdate _____

Married Widowed Single Minor Separated Divorced

Occupation _____

Patient Employer/School _____

How did you hear about our office? _____

Father's Name (if patient is a minor) _____

Birthdate _____ SS# _____

Address if different from above _____

Mother's Name (if patient is a minor) _____

Birthdate _____ SS# _____

Address if different from above _____

Dental Insurance/Financial Information

Primary Subscriber Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Employer Name _____

Insurance Co. _____

Insurance Co. Phone # _____

Group # _____

Is patient covered by additional insurance Yes No

Secondary Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Employer Name _____

Insurance Co. _____

Insurance Co. Phone # _____

Group # _____

Phone Numbers

Home (____) _____ Work (____) _____ Ext _____ Cell Phone (____) _____

Spouse's Name _____ Spouse's Work _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household)

Name _____ Relationship _____

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

Dental History

Reason for today's visit _____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Cigarette, pipe or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Phone # (____) _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays _____	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Place a mark on "Yes" or "No" to indicate if you have had any of the following:	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
Burning sensation on tongue ... <input type="checkbox"/> Yes <input type="checkbox"/> No	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
	Loose teeth or broken fillings ... <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____



Health History

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drug collectively referred to as "fen-Phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentemine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Place a mark on "Yes" or "No" to indicate if you have any of the following:

- | | | |
|--|--|---|
| AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally, with
extractions or surgery <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth
on head or neck <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent or bloody .. <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No | Herbal Supplements <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No | If so list _____ |

Women:

Are you pregnant? Yes No Due Date _____ Are you nursing? Yes No
Taking birth control pills? Yes No

<p>Medications</p> <p>List any medications you are currently taking and the correlating diagnosis:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Pharmacy Name _____</p> <p>Premed Rx _____</p> <p>Phone (_____) _____</p>	<p>Allergies</p> <p><input type="checkbox"/> Aspirin <input type="checkbox"/> Local Anesthetic</p> <p><input type="checkbox"/> Barbiturates <input type="checkbox"/> Penicillin</p> <p><input type="checkbox"/> Codeine <input type="checkbox"/> Sulfa</p> <p><input type="checkbox"/> Iodine <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Latex _____</p>
---	---

Assignment & Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. 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 payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group 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 services rendered on my behalf or my dependents.

X _____ Date _____

Signature of patient (or parent/guardian if minor)

Updates (for clial use only) _____
