AVENUE DENTAL GROUP

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REFERRED BY: _____ DATE: _____

PATIENT INFORMATION FORM

(PLEASE PRINT)

PATIENT:

Full Name: _____ Home Phone: _____
Cell Phone: _____ Work Phone: _____
Home Address: _____
(Street Address) (City) (State) (Zip)
Email Address: _____

CIRCLE ONE:

Minor Single Married Widowed Divorced Separated
Birth Date: _____ Age: _____ Gender: Male Female

PERSON RESPONSIBLE FOR ACCOUNT:

Full Name: _____ Home Phone: _____
Cell Phone: _____ Work Phone: _____
Home Address: _____
(Street Address) (City) (State) (Zip)
Employer: _____ How Long: _____ Position: _____
Employer Address: _____

SPOUSE:

Full Name: _____ Employer: _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Full Name: _____ Relationship: _____ Phone: _____

DENTAL INSURANCE:

Insurance Co.: _____ Address: _____
Employee: _____ Soc. Sec. #: _____ Group #: _____
Employee Birthdate: _____
Employer: _____ Address: _____

Are you covered under any additional dental insurance plans? YES NO (If YES, complete following)
Insurance Co.: _____ Address: _____
Employee: _____ Soc. Sec. #: _____ Group #: _____
Employee Birthdate: _____
Employer: _____ Address: _____

How will you handle payment of dental services? CASH/CHECK INSURANCE MC/VISA/DISC/AMEX CARECREDIT

PLEASE SEE OTHER SIDE

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? . . . . . Yes No
If yes, for what? _____
Physician's Name _____ Phone _____
Address _____ City _____ State _____ Zip _____

2. Have you taken any medication or drugs during the past two years? . . . . . Yes No

3. Are you taking any medication, drugs or pills now? . . . . . Yes No
If yes, please list name and dosage _____

4. Are you aware of having an allergic (**or adverse reaction**) to any medication or substance? . . . . . Yes No
If yes, please list: _____

5. Have you been a patient in the hospital during the past five years? . . . . . Yes No

6. When was your last dental visit? _____ When was your last dental cleaning? _____

7. Indicate which of the following you have had, or have at present. ***CIRCLE "YES" OR "NO" TO EACH ITEM.***

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (infectious) B (serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact Lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

8. Do you smoke or use smokeless tobacco? . . . . . Yes No

9. Have you lost or gained more than 10 pounds in the past year? . . . . . Yes No

10. Do you have or have you had any disease, condition, or problem not listed? . . . . . Yes No
If yes, please list _____
Does this medical condition prohibit or limit the administration of dental anesthetic, nitrous oxide, or restrict treatment of your dental needs in any way? Yes No If yes, list restrictions: _____

11. Women. Are you: **Pregnant?** Yes _____ Months **No** **Nursing?** Yes No **Taking birth control pills?** Yes No

TERMS AND CONDITIONS

1. This is to certiy that I, the undersigned, consent to the performing of all dental and oral surgical procedures agreed to be necessary or advisable.
2. I am financially reponsible for all services rendered to myself and/or my dependents and further authorize and request any insurance benefits be paid directly to Brian A. Stark, D.D.S., S.C. d/b/a Avenue Dental Group.
3. I understand that interest at the legal prevailing rate may be added to Past Due Balance.
4. I agree to pay for all collection or legal fees and costs reasonably incurred in connection with obtaining payment for this account.
5. I understand all the questions correctly to the best of my knowledge and understand all the statements herein.

Date _____ Patient's Signature (if minor, parent's signature) _____

I asked the patient all the questions in this application and the answers are recorded as given to me.