



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 certify 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 responsible for all services rendered to myself and/or my dependents and further authorize and request any insurance benefits be paid directly to Eyad Bittar, D.D.S., L.L.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.