WELCOME

Fulton Family Dentistry

******these forms are due back to us 24 hours prior to your appointment or we will have to reschedule*****

PATIENT INFORMATION

Today's Date: _____

Patient Name: _____

Patient's Date of Birth: _____

Patient's Address: _____

Patient's Social Security #: _____

_____

Patient's Phone #: _____

Email: _____

Cell Phone #: _____

Patient's Age: _____ Sex: _____

Marital Status: _____

Emergency Contact/Relationship to Patient: _____

RESPONSIBLE PARTY

Responsible Party: _____

Date of Birth: _____

Address: _____

Social Security #: _____

_____

Phone#: _____

_____

Cell Phone #: _____

Relationship to Patient: _____

Work Phone #: _____

INSURANCE INFORMATION

Name of Insured: _____

Relationship to Patient: _____

Address: _____

Date of Birth: _____

_____

Social Security #: _____

Employer: _____

Phone: _____

Group #: _____

Insurance Company: _____

Phone #: _____

Address: _____

Member #:_____

_____

ADDITIONAL INSURANCE

Name of Insured: _____

Relationship to Patient: _____

Employer: _____

Social Security #: _____

Insurance Company: _____

Date of Birth: _____

Address: _____

Phone: _____

_____

Group #: _____

PATIENT MEDICAL HISTORY

Primary Care Physician: _____ Phone #: _____ Date of Last Exam: _____
Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Have you ever been told you have one of the following? Check only if the answer is yes.

___ Heart Disease
___ Alzheimer's disease
___ Anaphylaxis
___ Angina
___ Convulsions
___ Artificial Heart Valve
___ Heart Attack
___ Fainting/Seizures
___ Chest Pain
___ Heart Murmur
___ Heart Pacemaker
___ Hemophilia
___ Congenital Heart Defect
___ Rheumatic Fever
___ High Blood Pressure
___ Low Blood Pressure
___ Stroke
___ Glaucoma
___ Leukemia
___ Mitral Valve Prolapse
___ Sexually Transmitted Disease

___ Anemia
___ Asthma
___ Blood Disease
___ Cancer
___ Cortisone Medicine
___ Excessive Bleeding
___ Bleeds Easily
___ Swollen Ankles
___ Epilepsy
___ Lung Disease
___ Jaw Pain
___ Hay Fever/Allergies
___ Arthritis
___ Joint Replacement/Implant
___ Liver Disease
___ Hepatitis
___ Jaundice
___ Psychiatric Therapy/Care
___ AIDS/HIV
___ Kidney Disease

___ Blood Transfusion
___ Breathing Problem
___ Bruise Easily
___ Cold Sores/Fever Blisters
___ Excessive Thirst
___ Frequent Cough
___ Shortness of Breath
___ Osteoporosis/Osteopenia
___ STD
___ Hypoglycemia
___ Tuberculosis
___ Sinus Trouble
___ Emphysema
___ Recent Weight Loss
___ Diabetes
___ Radiation Therapy
___Thyroid Disease
___ Stomach Ulcer
___ Other _____
_____
_____

Yes NO
___ ___ 1. Are you under physician's care now? If yes, please explain: _____
___ ___ 2. Have you ever been hospitalized or had a major operation? If yes, please explain: _____
_____3. Have you ever had a serious head or neck injury? If yes, please explain _____
___ ___ 4. Are you currently taking any medications? **If yes, please list**: _____
_____
___ ___ 5. Do you take, or have you taken, Phen-fen or Redux? If yes, please explain: _____
___ ___ 6. Do you use tobacco? _____
___ ___ 7. Do you use Alcohol, or Controlled Substances? If yes, please explain: _____
___ ___ 8. Allergies to any medication? List: _____
___ ___ 9. Women Only: Are you pregnant or think you may be pregnant? What month: _____
Are you taking birth control pills? _____
How did you hear about our office? _____

PATIENT DENTAL HISTORY

What is your reason for seeking care: _____ Date of last dental care: _____
Former Dentist: _____ Date of last dental X-rays: _____
Address/Phone: _____
Check if you have had problems with any of the following:

___ Bad breath
___ Sensitivity to cold
___ Sensitivity to sweets
___ Food collection between the teeth
___ Grinding teeth
___ Bleeding Gums
___ Clicking or popping jaw
___ Sores or growths in your mouth
___ Sensitivity to hot
___ Loose teeth or broken fillings
___ Sensitivity to biting

Have you had surgery performed on your gums? _____ Have you ever had periodontal treatment? _____
Do you wear Dentures? _____ Do you grind your teeth? _____ Do you floss? How often _____
How many times a day do you brush your teeth? _____
Are you happy with the brightness of your smile? _____ Would you like to hear about our Whitening Special? _____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly
Name of Insurance Company(ies)
to Dr. Wadood all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I authorize my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned hereby authorizes Fulton Family Dentistry to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize Fulton Family Dentistry to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that Fulton Family Dentistry choose and employ such assistance as deemed necessary. I understand that the use of local anesthetics agents embodies certain risk and consent to their use as deemed appropriate by Fulton Family Dentistry. To the best of my knowledge, the questions on the form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/the patients' health. It is my responsibility to inform the dental office of any change in my medical health or status.

_____ Date: _____
Signature of Patient, Parent, Guardian, or Personal Representative

_____ Relationship to Patient: _____
Please print name of Patient, Parent, Guardian, or Personal Representative

Payment is due in full at the time of treatment unless prior arrangements have been approved.