FAIRINGTON
FAMILY DENTAL

PATIENT INFORMATION

Name _____ Birthdate _____ Phone (_____) _____

Address _____ City _____ State _____ Zip _____

Sex ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for _____ years

E-mail _____ Alt. Phone (_____) _____

Employer/School _____ Employer/School Phone (_____) _____

Employer/School Address _____ City _____ State _____ Zip_____

Emergency Contact _____ Phone (_____) _____

RESPONSIBLE PARTY

Name _____ Relation to Patient _____ Birthdate _____

Address _____ Phone (_____) _____

Employer _____ Work Phone (_____) _____

E-mail _____ Cell Phone (_____) _____

Currently a patient in our office? ☐ Yes ☐ No

INSURANCE INFORMATION

Name of Subscriber _____ Relation to Patient _____

Birthdate _____ Social Security # _____

Employer _____ Work Phone (_____) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ ID # _____

Address _____ City _____ State _____ Zip _____

ADDITIONAL INSURANCE

Name of Subscriber _____ Relation to Patient _____

Birthdate _____ Social Security # _____

Employer _____ Work Phone (_____) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ ID # _____

Address _____ City _____ State _____ Zip _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental appointment _____

Former Dentist _____ Date of last dental X-rays _____

Check (✓) if you have had problems with any of the following:

☐ Bad breath ☐ Grinding teeth ☐ Sensitivity to hot ☐ Bleeding gums

☐ Loose teeth or broken fillings ☐ Sensitivity to sweets ☐ Clicking or popping jaw ☐ Sensitivity to cold

☐ Periodontal treatment ☐ Sensitivity when biting ☐ Food collection between the teeth

☐ Sores or growths in your mouth How often do you floss? _____ How often do you brush?_____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

- Have you ever used bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No
- Have you ever taken any of the groups of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No
- Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____
- Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____
- Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Anemia	☐	☐	Cough,	☐	☐	HIV/AIDS	☐	☐	Sexually Transmitted Disease
☐	☐	Arthritis, Rheumatism	☐	☐	Diabetes	☐	☐	Jaw Pain	☐	☐	Shortness of Breath
☐	☐	Artificial Heart Valves	☐	☐	Drug/Alcohol	☐	☐	Kidney Disease	☐	☐	Skin Rash
☐	☐	Artificial Joints, Pins, etc	☐	☐	Epilepsy	☐	☐	Liver Disease	☐	☐	Stroke
☐	☐	Asthma	☐	☐	Fainting	☐	☐	Lung Disease/COPD	☐	☐	Swelling of Feet/Ankles
☐	☐	Back Problems	☐	☐	Glaucoma	☐	☐	Mental Health	☐	☐	Thyroid Problems
☐	☐	Blood Disease	☐	☐	Heart Murmur	☐	☐	Migraines	☐	☐	Tobacco Habit
☐	☐	Cancer	☐	☐	Heart Problems	☐	☐	Pacemaker	☐	☐	Tonsillitis
☐	☐	Chemical Dependency	☐	☐	Hemophilia	☐	☐	Radiation Treatment	☐	☐	Tuberculosis
☐	☐	Chemotherapy	☐	☐	Hepatitis	☐	☐	Respiratory Disease	☐	☐	Ulcers
☐	☐	Circulatory Problems	☐	☐	High Blood						

List medications you are currently taking:

_____

_____

_____

Allergies:

_____

_____

_____

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 to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of 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.

_____ _____ _____

Signature of Patient, Parent, Guardian or Representative **Relationship** **Date**