Adult Patient Information

Please select: □Dr. □Mr. □Mrs. □Ms.

Name (First, Last):_____

Date of Birth: _____ **Gender: □Male □Female □Non-Binary**

Telephone Number: _____ **Email:** _____

Full Street Address: _____

Marital Status: Single Married Widowed Separated Divorced

What is the primary contact for your treatment? Call Email Text

General Dentist (Required):_____

Referral Source: _____

Referral Recommendation for Scheduled Consultation: _____

Who will make the financial payments for services rendered at West End Avenue Pediatric & Adult Dentistry: Myself

Other _____

If you have selected other please completed the following:

Please select: Dr. Mr. Mrs. Ms.

Name (First, Last):_____

Date of Birth: _____ **Gender: Male Female Non-Binary Full**

Street Address: (Same as above) _____

Telephone Number: _____ **Email:** _____

Marital Status: Single Married Widowed Separated Divorced

Relationship to patient: _____

Emergency Contact Information

In case of an emergency, please provide the name of the nearest relative <u>not living with you</u>:

Emergency Contact's Name (First, Last):_____

Emergency Contact's relationship to patient: _____

Emergency Contact's Phone Number:_____

Dental Insurance Information (Primary)

Policy Holder's Full Name: _____**Policy Holder's Date of Birth: __ __/ __ __/ __ __ __ __**

Employer's Name: _____ **Policy Holder's SSN: ___ ___ ___ - __ __ - __ __ ___ ___**

Insurance Company: _____**Policy Holder ID Number:** _____

Group Number: _____ **Insurance Company Address:** _____

Medical History

Physician's full name: _____

Physician's Phone Number: _____

Describe your current health status_____ **Date of last Visit:** _____

Patient's Height _____ **Patient's Weight** _____

Pharmacy Name: _____ **Pharmacy Number:** _____

Pharmacy Address: _____

Select any of the following medical/health concerns (Check all that apply past/present)

- ☐Abnormal Bleeding
- ☐ Anemia
- ☐Artificial Bones
- ☐Joints Valve
- ☐Asthma
- ☐Arthritis
- ☐Attention Deficit Disorder
- ☐ Blood Transfusion
- ☐Cancer
- ☐Chemotherapy
- ☐Congenital Heart Defect
- ☐Diabetes
- ☐Difficult Breathing
- ☐Drug Abuse
- ☐Emphysema
- ☐Epilepsy
- ☐Seizures
- ☐Fainting
- ☐Fever Blisters
- ☐ Herpes
- ☐ Handicap Disabilities
- ☐ Heart Attack / Stroke
- ☐Heart Murmur
- ☐Heart Surgery
- ☐Pacemaker
- ☐Hemophilia
- ☐Hepatitis
- ☐Low Blood Pressure
- ☐High Blood Pressure
- ☐HIV+
- ☐AIDS
- ☐Hospitalized for Any Reason
- ☐Kidney Problems
- ☐Menstruation
- ☐Mitral Valve Prolapse
- ☐Psychiatric Condition
- ☐Radiation Treatment
- ☐Rheumatic/ Scarlet Fever
- ☐Severe / Frequent Headaches
- ☐Sickle Cell Disease/ Traits
- ☐Sinus Problems
- ☐Sleep Apnea
- ☐TMD
- ☐TMJ
- ☐Tuberculosis
- ☐Ulcers/ Colitis
- ☐No Medical Conditions

Are you allergic to any of the following?

- ☐Aspirin
- ☐Any Metals/Plastics
- ☐Codeine
- ☐Dental Anesthetics
- ☐Erythromycin
- ☐Latex
- ☐Penicillin
- ☐Amoxicillin
- ☐Tetracycline
- ☐Other (Please indicate in the entry below)

Other Allergies: _____

Have you had any illness, operation or been hospitalized in the past five years? ☐ **Yes** ☐ **No**

Do you have any unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?

☐ **Yes** ☐ **No**

Have you had a heart valve replacement or vascular graft? ☐ **Yes** ☐ **No**

Have you previously had general anesthesia or IV sedation? ☐ **Yes** ☐ **No**

Have you, or a family member, had any unusual or serious reactions to general anesthesia or IV sedation? ☐ **Yes** ☐ **No**

If yes, any history of complications with anesthesia such as post-operation nausea, vomiting or fever, or any other complications?

_____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ Yes ☐ No

Please list any medication that you are taking: _____

Discuss any other medical concerns you may have: _____

Financial Agreement

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status and updates to my account. I authorize the dental staff to perform the necessary dental service I may need. I understand that I am responsible for payment of services rendered at this office. I hereby authorize the dentist to release all information necessary to secure the payment of benefits.

Please sign and date:_____

Authorization for Release of Patient Information to Second Party

I, _____ authorize West End Avenue Pediatric & Adult Dentistry to discuss all/any health information,

dental records, insurance information, and financials with (other than yourself) _____ _____ .

Please sign and date:_____

Authorization for Release of Records

West End Avenue Oral Surgery's goal is to help reduce paper waste. By providing your name and email address here, you are giving us permission to send your records to you digitally if requested.

Full Name: _____
Email Address: _____
Sign: _____ Date: _____

Authorization for Release of Patient Health Information: I hereby authorize the above doctor(s) to provide other health care providers with information regarding the above individual's dental care as deemed appropriate. I authorize this facility to share my PHI with other entities, such as insurance companies, or family members, for specific purposes like treatment, payment, or healthcare operations. I understand that once released, the above doctor(s) and staff has (have) no responsibility for any future release by the individual receiving this information.
Please Initial: _____