Avenue D Professional Group DDS PC

Patient Information

Patient Name: _____ **Date:**_____

If patient is a minor, parent's name: _____

Social Security #: _____ **Date of Birth:**_____

Single: _____ **Married:**_____**Separated:** _____ **Divorced:** _____ **Widowed:** _____

Home Address: Street: _____ **Apt. #:** _____

City: _____ **State:** _____ **Zip** _____

Home #: _____ **Cell #:** _____ **Work #:** _____

Email: _____**Referred by :** _____

Reason for this visit: _____

Who will pay this account?: _____

Responsible party -- please fill out the information below:

Employed By: _____

Primary Insurance Carrier: _____

Policy #: _____

Spouse Employed By: _____

Secondary Insurance Carrier: _____

Policy #: _____

Important: Please fill out the medical history on the reverse side.

Patient Medical History

Please complete this questionnaire

	Circle One	
1. Are you under the care of a doctor or a physician?	yes	no
2. Are you currently taking any medications or drugs?	yes	no
3. Do you have any allergies?	yes	no

4. Have you ever had a bad reaction to?

Penicillin	yes	no	Codeine	yes	no
Aspirin	yes	no	Erythromycin	yes	no
Novacaine	yes	no	Tetracycline	yes	no

5. Have you ever had any of the following?

Heart Condition	yes	no	Abnormal Bleeding	yes	no
Heart Murmur	yes	no	Diabetes	yes	no
Seizures	yes	no	Thyroid Condition	yes	no
Stroke	yes	no	Ulcers	yes	no
Tuberculosis	yes	no	Hepatitis	yes	no
Asthma	yes	no	Anemia	yes	no
High Blood Pressure	yes	no	Liver Problems	yes	no
Low Blood Pressure	yes	no	Kidney Problems	yes	no

6. Have you ever had Joint Replacement Surgery? yes no

7. Do you have any medical conditions not mentioned above? yes no
   If yes, please specify_____

8. Have you ever had to go to the hospital as a patient? yes no
   If yes, please specify_____

9. Are you pregnant? yes no

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by Avenue D Professional Group and staff to help determine appropriate and healthful dental treatment. I will notify the dentist of any changes in my medical status. I authorize my insurance company to pay Avenue D Professional Group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions as well as the release of all information necessary to secure the payment of benefits. I hereby give my consent to Avenue D Professional Group and staff to perform the indicated dental treatment on me/or my child.

Signature_____Date_____

Signature of guardian (if minor)_____