FIRST STREET DENTAL *Annual Update*

Patient Name: ____ Date: ________________

Since your last visit, have you changed your contact information? ☐ Yes ☐ No

Address ____ City ______________________________ Zip Code ____________

Home Phone ( ) ______________________________ Work Phone ( ) ______________________________

Cell Phone ( ) ______________________________ Email Address ______________________________

What is the best way to contact you? ____

Medical Physician's Name ____ Date of last visit ____________________

In the last 12 months have you seen a medical doctor? ☐ Yes ☐ No If yes, for what? ______________________________

In the last 12 months have you had a visit to the ER/Urgent Care or had surgery? ☐ Yes ☐ No If yes, for what? ____________________

Medications currently taking with dosage and for what condition: ____

____

Have you ever taken IV or oral bisphosphonates (e.g. Fosamax, Actonel, Boniva, etc.) for the treatment of osteoporosis, cancer or Paget's disease? ☐ Yes ☐ No If yes, which medication and the date started: ____

Do you use chewing tobacco or smoke? ☐ Yes ☐ No If yes, how much? ____

Are you sensitive or allergic to any drugs or materials: ☐ Yes ☐ No ☐ Penicillin ☐ Tetracycline ☐ Aspirin ☐ Codeine ☐ Latex ☐ Sulfa ☐ Local Anesthetic ☐ Iodine ☐ Sedatives ☐ Food ____________________ ☐ Other ____________________

Are you using any recreational drugs (marijuana, cocaine, etc.) ☐ Yes ☐ No If yes, what? ______________________________

Do you consume alcoholic beverages? ☐ Yes ☐ No If yes, how many per day?: _________ How many per week?: __________

Do you wear contact lenses? ☐ Yes ☐ No

Women: Are you pregnant? ☐ Yes ☐ No Due date __________ Are you nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Do you have or have you had any of the following:
(Please check each box individually - "YES" or "NO" for each condition)

Condition	Yes/No
AIDS/HIV	☐ Yes ☐ No
Allergies to Metals	☐ Yes ☐ No
Anemia	☐ Yes ☐ No
Angina Pectoris	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No
Asthma	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No
Bleeding abnormally, with extraction or surgery	☐ Yes ☐ No
Blood disease/Hemophilia	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No
Cancer	☐ Yes ☐ No
Cerebral Palsy	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No
Chicken Pox	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No
Cold Sores	☐ Yes ☐ No
Congenital Heart Disease	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No
Diet drugs, Fen-Phen, Redux	☐ Yes ☐ No
Difficulty Swallowing	☐ Yes ☐ No
Drug Addiction	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No
Fainting or dizziness	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No
Hay Fever/Rhinitis	☐ Yes ☐ No
Headaches	☐ Yes ☐ No
Heart Attack	☐ Yes ☐ No
Head Injury	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No
Heart Problems	☐ Yes ☐ No
Heart Transplant	☐ Yes ☐ No
Hepatitis Type _____	☐ Yes ☐ No
Herpes	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No
Implants	☐ Yes ☐ No
Infective Endocarditis	☐ Yes ☐ No
Jaundice	☐ Yes ☐ No
Jaw Pain/TMJ	☐ Yes ☐ No
Kidney Disease	☐ Yes ☐ No
Liver Disease	☐ Yes ☐ No
Low Blood Pressure	☐ Yes ☐ No
Mitral Valve Prolapse	☐ Yes ☐ No
Nervous Problems	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No
Psychiatric Care	☐ Yes ☐ No
Radiation Treatment	☐ Yes ☐ No
Respiratory Disease	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No
Scarlet Fever	☐ Yes ☐ No
Shortness of Breath	☐ Yes ☐ No
Sickle Cell Disease	☐ Yes ☐ No
Sinus Trouble	☐ Yes ☐ No
Skin Rash/Hives	☐ Yes ☐ No
Special Diet	☐ Yes ☐ No
Stroke	☐ Yes ☐ No
Swollen Feet or Ankles	☐ Yes ☐ No
Swollen Neck Glands	☐ Yes ☐ No
Thyroid Problems	☐ Yes ☐ No
Tonsillitis	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No
Tumor/growth on head/neck	☐ Yes ☐ No
Ulcer	☐ Yes ☐ No
Venereal Disease	☐ Yes ☐ No
Weight Loss, unexplained	☐ Yes ☐ No

Do you have any disease, condition or problem not listed above that we should know about? ☐ Yes ☐ No

If yes, please list ______________________________

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I AGREE TO NOTIFY THE DENTIST IF I EVER HAVE ANY CHANGES IN MY HEALTH AND/OR MEDICATION.

Patient/RP Signature: ______________________________ Date: ______________

Doctor's Signature: ______________________________ Date: ______________

Doctor's Comments ____

____

Since your last visit, have you changed your Insurance? ☐ Yes ☐ No

Dental Insurance Co. ______________________________ Group # ______________

Employer ____

Employee Name ______________________________ Employee Date of Birth ______________

Employee Social Security Number ______________________________ Employee ID Number ______________

ASSIGNMENT OF INSURANCE:

I hereby authorize my insurance company to pay First Street Dental directly for any dental benefits otherwise payable to me.

Signed: ______________________________ Date: ____________ Relationship to patient: ______________

CONSENT:

1. The undersigned hereby authorizes First Street Dental to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient whose name appears on this form.

2. I authorize First Street Dental to perform all recommended treatment mutually agreed upon by myself and to use the appropriate medication and therapy indicated for such treatment in connection with ______________________________'s treatment.
   Print name of patient

3. I authorize First Street Dental to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous or non-intravenous sedation mutually agreed upon. I understand that using anesthetic agents embodies a certain risk. I have been informed of all possible complications of the procedures, anesthetics and/or drugs recommended.

4. I understand that all responsibility for payment for dental services provided in this office for myself and/or the patient whose name appears on this form, is mine, due and payable at the time services are rendered unless other financial arrangements have been made in advance of treatment. In the event payment(s) are not received by the agreed upon dates, I further understand that 1½ % - 2% finance charge (18% - 24% APR) may be added to my account in addition to late payment fees, collection charges, attorney's fees, and/or court costs incurred to satisfy my financial obligation. I understand that where appropriate, credit bureau reports may be obtained.

5. I further understand that if I have dental insurance, my insurance coverage is an agreement between myself and my third party carrier and that it is my responsibility to be familiar with the terms, coverage, and limitations of my individual policy.
   I authorize release of any information necessary for the processing of any dental claims submitted on my behalf to my insurance carrier.

6. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

7. I further understand that fee estimates given are valid for up to three months from the date of my evaluation/examination.

8. I hereby grant permission to you, or your assignees, to telephone me at home, at work, on my cell phone/text message, and/or by email: ______________________________ to discuss matters relating to this form, treatment, and/or my account.

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Print Responsible Party Name | *Responsible Party Signature* | *Relationship to Patient* | *Date*

All services are rendered and accepted under the terms and conditions noted on this form.