



PARKWAY
DENTAL
& ASSOCIATES

Close to the beach. Far from ordinary.

W E L C O M E

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date _____ Home Phone(_____) _____ Cell Phone (_____) _____

Name _____ SS/HIC/Patient ID# _____

Last First MI

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthday _____ Married Widowed Single Minor

Separated Divorced Partnered for _____ yrs

Patient Employer/School _____ Occupation _____

Whom may we thank for referring you? _____

In case of emergency, who should be notified? _____ Phone(_____) _____

Dental Insurance

Person Responsible for Acct _____

Last First MI

Relation to Patient _____ Birtday _____ ID#/SS# _____

Address (If different from pt's) _____ Phone(_____) _____

City _____ State _____ Zip _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone(_____) _____

Insurance Company _____ Contract # _____

Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Additional Dental Insurance

Is patient covered by additional insurance? Yes No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (If different from patient's) _____ Phone(_____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone(_____) _____

Insurance Company _____ SS# _____ Contract # _____

Group # _____ Subscriber # _____

Payments

I UNDERSTAND PAYMENT IS DUE AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMNTS HAVE BEEN APPROVED

Sign Name _____

Dental History

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental x-rays _____

Address/Phone # of last Dentist _____

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Sensitivity to Hot or Cold |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Loose Teeth | <input type="checkbox"/> Sensitivity to Sweets |
| <input type="checkbox"/> Clicking or Popping Jaw | <input type="checkbox"/> Periodontal Therapy | <input type="checkbox"/> Sensitivity when Biting |
| <input type="checkbox"/> Food Collection between Teeth | <input type="checkbox"/> Broken Fillings | <input type="checkbox"/> Sores or Growths in your Mouth |

How often do you brush? _____ Floss? _____

Medical History

Physician's Name _____ Date of Last Visit _____

List all serious illnesses: _____

List all operations w/ dates: _____

Women: Are you Pregnant? Yes No Have you ever had a blood transfusion? Yes No

Nursing? Yes No If yes, give approximate dates _____

Taking Birth Control Pills? Yes No

Check (√) if you have or have had any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Swelling of Feet of Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral valve Prolapse | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |

Please list medications you are taking:

Allergies:

Authorization

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 my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, guardian or Personal Representative _____ Date _____

Please print name of Patient, Parent, Guardian or Personal Representative _____ Date _____