

**Park Place Dental**

**Family Dentistry**

210 West Park Place, Newark, DE 19711

302-455-0333 Fax 302-368-3608

Parkplacedental210@gmail.com

**PATIENT INFORMATION AND HEALTH RECORD**

Name \_\_\_\_\_ Date \_\_\_\_\_  
(Last) (First) (MI)

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_\_

Social Security # \_\_\_\_\_ Personal Physician \_\_\_\_\_

Business Phone \_\_\_\_\_ Occupation \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Employers Name & Address \_\_\_\_\_

Person Responsible for bill if address different \_\_\_\_\_

Referred By \_\_\_\_\_ Closest Relative \_\_\_\_\_

Spouses Name, Birth Date, Employer \_\_\_\_\_

Family Members who use this office \_\_\_\_\_

Dental Insurance \_\_\_\_\_ Employer \_\_\_\_\_

(List All) \_\_\_\_\_ Employer \_\_\_\_\_

Insured person's name if different \_\_\_\_\_ SS# \_\_\_\_\_

**Dental Health**

Reason for Visit \_\_\_\_\_ Last Dental Visit \_\_\_\_\_

Have you ever had any serious problems associated with a previous dental visit? \_\_\_ If yes, explain \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ Texture of brush \_\_\_\_\_ Do your gums feel swollen? \_\_\_\_\_ Do you grind or clench your teeth? \_\_\_\_\_

**Medical Health**

Date of last complete physical \_\_\_\_\_ Are you presently under the care of a physician? \_\_\_\_\_

If yes, explain \_\_\_\_\_

Have you been in the hospital or had any serious illness within the past five years? \_\_\_\_\_ If yes, explain \_\_\_\_\_

Have you had any radiation treatment for tumors, growths, etc? \_\_\_\_\_

Do you have any artificial limbs, joints, heart valves, shunt appliances, etc? Explain \_\_\_\_\_

Are you allergic to: Penicillin \_\_\_\_\_ Codeine \_\_\_\_\_ Injected Anesthetics \_\_\_\_\_ Other \_\_\_\_\_

Have you ever taken Bisphosphonates? \_\_\_\_\_ Are you currently on a blood thinner? \_\_\_\_\_

Are you taking any medications or drugs for any reasons? \_\_\_\_\_ If yes, explain \_\_\_\_\_

**Have you ever had or been treated for any of the following, please circle:**

Congenital Heart Lesions	Yes	No	Heart Murmur	Yes	No
Heart Disease	Yes	No	Jaundice	Yes	No
Rheumatic Fever	Yes	No	Asthma/ Hay Fever	Yes	No
High Blood Pressure	Yes	No	Sinus Trouble	Yes	No
Ulcers	Yes	No	Lung Disease	Yes	No
Tuberculosis	Yes	No	Hepatitis	Yes	No
Diabetes	Yes	No	Arthritis	Yes	No
Epilepsy	Yes	No	Stroke	Yes	No
Anemia	Yes	No	Glaucoma	Yes	No
Kidney Disease	Yes	No	Venereal Disease	Yes	No
Syphilis	Yes	No	Blood Clots	Yes	No
Hemophilia	Yes	No	Hemodialysis	Yes	No
Herpes	Yes	No	Physical Disability	Yes	No
ARC or Aids	Yes	No	Learning Disability	Yes	No

Do you have any allergies? \_\_\_\_\_ If yes, to what? \_\_\_\_\_

Women: Are you pregnant now? \_\_\_\_\_ Due Date: \_\_\_\_\_

Have you received blood for any reason? \_\_\_\_\_ If yes, explain \_\_\_\_\_

Have you ever been tested for AIDS? \_\_\_\_\_ Do you have any blood disorder? \_\_\_\_\_

If yes, explain \_\_\_\_\_

Do you have prolonged bleeding when cut? \_\_\_\_\_

Please list any medical condition you may have that is not listed above \_\_\_\_\_

Do you have any special requests or comments? \_\_\_\_\_

Patient's Signature \_\_\_\_\_

(Parent if minor)

**All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office.**

**Insurance Authorization of Assignment**

**I hereby authorize Dr. \_\_\_\_\_ to furnish information to insurance carriers concerning my treatments and I hereby assign to the dentist(s) all payments for dental services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.**

Signature \_\_\_\_\_ Date \_\_\_\_\_