WELCOME TO SILVERMAN DENTAL

Today's date: _____

Are you filling this form out for someone else? If yes, are they an: _____adult or _____child

Name: _____ Prefer to be called: _____

Address: _____Zip Code: _____

Home/Work Phone: _____ Cell Phone: _____ Male ____ Female____

Birthdate: _____ SS #: _____ Email: _____

Employer: _____Occupation: _____

Marital Status: _____Single _____Married _____Divorced _____Separated _____Widowed

Spouse Info: Name: _____Birthdate: _____Employer: _____

Whom may we thank for referring you? _____

Previous/present Dentist: _____Last dental visit date: _____

PARENT INFO (If patient is under 18):

Name: _____

Phone #: _____

DOB: _____

Person responsible for account:

Name: _____

Phone #: _____

Relation: _____ DOB: _____

DENTAL INSURANCE:

<u>Primary:</u>

Insurance Co. Name: _____
Insurance Co. Phone: _____
Subscriber ID #: _____
Group/Plan #: _____
Insured's Name: _____
Relation: _____ DOB: _____
Insured's Employer: _____

<u>Secondary:</u>

Insurance Co. Name: _____
Insurance Co. Phone: _____
Subscriber ID#: _____
Group/Plan #: _____
Insured's Name: _____
Relation: _____ DOB: _____
Insured's Employer: _____

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

I have read and agreed to the above:

X_____Date: _____

Please complete the health history by circling **"No"** for conditions that do not apply and **"Yes"** for conditions that do apply. If more than one condition appears in the same column next to "Yes," please circle the specific health condition that applies.

Y	N	ADD/ADHD	Y	N	Hemophilia/Abnormalbleeding
Y	N	Anemia	Y	N	Hepatitis
Y	N	Artificial Bones/joints/valves	Y	N	High Blood Pressure
Y	N	Arthritis	Y	N	Low Blood Pressure
Y	N	Asthma/Emphysema	Y	N	HIV+/AIDS
Y	N	Blood Transfusion	Y	N	Hospitalized for any reason
Y	N	Cancer	Reason: _____		
Y	N	Chemotherapy/Radiation	Y	N	Kidney Conditions
Y	N	Congenital Heart Defect	Y	N	Mitral Valve Prolapse
Y	N	Diabetes	Y	N	Osteoporosis
Y	N	Difficulty Breathing	Y	N	Taken Bisphosphonates
Y	N	Psychiatric Treatment	Y	N	Severe/ Frequent Headaches
Y	N	Rheumatic/Scarlet Fever	Y	N	Shingles
Y	N	Drug/Alcohol Abuse	Y	N	Sickle Cell Disease/ Traits
Y	N	Epilepsy/Seizures/Fainting	Y	N	Sinus Problems
Y	N	Fever Blisters/Herpes	Y	N	Tuberculosis (TB)
Y	N	Glaucoma/Eye Conditions	Y	N	Ulcers/ Colitis
Y	N	Hard of Hearing	Y	N	Venereal Disease
Y	N	Heart Attack/ Stroke	Y	N	Tobacco/Vape/THC
Y	N	Heart Murmur	Y	N	Heart Surgery/ Pacemaker

Please list any serious medical conditions that you have ever had:

_____

_____

_____

How often do you brush?

_____

How often do you floss?

_____

Do you have any dental concerns today?

_____

_____

_____

_____

_____

_____

Please list any medications or supplements you are currently taking:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Women: Are you Pregnant? Y N If yes, how many weeks? _____ Are you nursing? Y N

In the event of an emergency, who should we contact?

Name:_____Relation: _____ Phone:_____

Are you allergic to:

Y	N	Aspirin	Y	N	Erythromycin
Y	N	Codeine	Y	N	Dental Anesthetics
Y	N	Jewelry/Metal	Y	N	Tetracycline
Y	N	Penicillin	Y	N	Latex

OTHER:

_____

_____

Silverman Dental is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen. A 48-hour notice of cancellation must be given for all appointments. We reserve the right to charge a $100.00 fee for appointments cancelled or broken without 48 hours advance notice.

Signature: _____

Date: _____

I have received notice of this office's **Notice of Privacy Practices.**

I understand that the information that I have given today is correct and to the best of my knowledge. This information will be held in the strictest confidence and it is my responsibility to inform the office of any changes in medical status.

Signature:_____ Date:_____

Printed name:_____