FARMINGTON VILLAGE DENTAL
WHOLE FAMILY DENTISTRY

helping people make healthy choices

Patient Information:

Patient: _____ Today's Date: _____

I prefer to be called: _____

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

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Work: _____ Cell: _____

May we text you? ◯ Yes ◯ No E-Mail: _____@_____

Birth date: _____/_____/_____ Patient Social Security #: _____-_____-_____

How did you hear about our office? ◯ Patient: _____ ◯ Internet Search ◯ Mailer ◯ Website ◯ Other

Will you please inform the dentist or the staff at the beginning of each new office visit if your medical or dental conditions Changed since we last saw you? ◯ Yes ◯ No

Dental Insurance:

Insurance Co. Name: _____

Insurance Co. Phone: _____

Plan ID #: _____

Group #: _____

Policy Holders Name: _____

DOB: _____/_____/_____ Social: _____-_____-_____

Relationship to Patient: _____

Policy Holders Employer: _____

What is the most important quality for you in a relationship with a doctor?

_____

Are you the type of person who likes a lot of detailed information or do you prefer more bottom line information?

_____

Our office would like to have your permission to use your photos for articles, advertisements, office brochures and educational purposes. Please sign this agreement, which will give us your permission to use pictures of you and your smile.

Signature: _____ **Date:** _____

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Physicians Name: _____

Physicians Telephone: _____

Are you currently under the care of a physician?
If yes please explain: _____
_____

Are you currently taking any prescriptions, over the counter, herbs, supplements or recreational drugs?
If yes please explain: _____
_____
_____

Do you smoke or use any tobacco in any form? _____
Are you taking birth control pills? _____
Are you pregnant? _____
Are you nursing? _____

Do you require antibiotic before dental treatment? If yes please explain why: _____

Please provide us with your Pharmacy and the telephone number for our staff to call in prescription:
_____

Have you been hospitalized or had a serious illness within the past 5 year? If yes please explain: _____
_____

Please circle any of the following allergies or adverse reaction:

Penicillin	Aspirin	Iodine
Tetracycline	Valium	Codeine
Erythromycin	Barbiturates	Latex
Household Bleach	Advil/Motrin	Sulfa
Local Anesthetics	Other: _____	

Purpose of today's visit: _____

Last dental visit: _____ Last cleaning: _____

What was done? _____

How often do you brush? _____ Floss? _____

Do you use a Manual or Electric toothbrush? _____

Please mark all that apply:

Bleeding gums ☐ Loose teeth ☐ Teeth injury ☐
Broken fillings ☐ Jaw pain ☐

Do you like your smile? _____

Are you currently in pain? _____

Do you feel nervous about having dental treatment? ____

Have you ever had a bad experience in a dental office?
_____

Please circle yes or no if you have any of the following diseases or medical problems:

Y N Abnormal bleeding	**Y N** Pysc. Care
Y N Alcohol/Drug abuse	**Y N** Radiation
Y N Alzheimer's disease	**Y N** Scarlet fever
Y N Anemia	**Y N** Seizures
Y N Arthritis	**Y N** Sinus problem
Y N Artificial Bones	**Y N** Thyroid problem
Y N Asthma	**Y N** TB
Y N Blood Transfusion	**Y N** Tumors
Y N Bruise easily	**Y N** Ulcers
Y N Cancer/Chemotherapy	**Y N** Venereal disease
Y N Colitis	**Y N** Pacemaker
Y N Diabetic	**Y N** Mitral Valve Prolapse
Y N Difficulty breathing	**Y N** Low blood Pressure
Y N Emphysema	**Y N** Liver disease
Y N Epilepsy	**Y N** Kidney problems
Y N Fainting spells	**Y N** Joint replacement
Y N Frequent headaches	**Y N** HIV/AIDS
Y N Glaucoma	**Y N** Herpes/Blisters
Y N Hay fever	**Y N** Heart murmur
Y N Heart problems	**Y N** Hemophilia
Y N Hepatitis	
Y N High blood pressure	

Y N Do you have a history of substance abuse
If so, how long have you been in recovery? _____

We reserve the right to charge for any appointments not cancelled with 48 hours notice. Regardless of insurance, patients are fully responsible for any account balance. Patients are encouraged to ask all dental & medical Questions to ensure the understanding of the time, limitations, potential complications and cost of all treatment. I certify that all the information that I have provided is accurate to the best of my knowledge. I will not hold any member of the dental staff responsible for actions resulting from errors or omissions that I have made in the completion of this form. **HIPPA-**We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you a copy of our offices HIPPA privacy act, our legal duties, and your rights concerning your health information. This notice took effect 4/15/2003 and will remain in effect until we replace it. At that time you will be notified. **Insurance Assignment:** My signature authorizes the release of necessary information needed to process my claim and to pay any benefits to the provider of my service. (Farmington Village Dental, Dr. Monique Nadeau and Dr. Eric Krause)

Signature_____ Date_____