**Welcome To Paxton Family Dental**

**Patient Information**

Mr. Mrs. Ms. Dr. Last Name: M.I.: First Name:

Preferred Name: M F DOB: SS#:

Do you have any immediate family members that come here? Y N If yes, please write relation:

Mailing Address: City: State: Zip:

Home Phone: Cell: Other:

Preferred Contact Phone: Home Cell Other Email:

Would you like to receive email(s)? Y N Occupation: Employer:

*Whom may we thank for referring you to us?*

**Emergency Contact:**

Name: Relationship: Contact Phone:

**Person responsible for account:** Patient Guardian Spouse Father Mother

**Primary Dental Insurance**

**If no insurance, complete this section for the person responsible for this account.**

Last Name: M.I. First Name:

Mailing Address: City: State: Zip:

Home Phone: Cell: Other:

Preferred Contact Phone: Home Cell Other Email:

DOB: SS# Drivers Lic.: Relationship to Patient:

Employer: Dental Ins. Co.: Subscriber ID: Group #:

**Secondary Dental Insurance**

Last Name: M.I. First Name:

Mailing Address: City: State: Zip:

Home Phone: Cell: Other:

Preferred Contact Phone: Home Cell Other Email:

DOB: SS# Relationship to Patient:

Employer: Dental Ins. Co.: Subscriber ID: Group #:

**Payment/Authorization**

I understand that payment is due in full at each visit unless otherwise agreed upon in writing. I hereby authorize payment directly to Paxton Family Dental of the group insurance otherwise payable to me. I understand I am responsible for all costs of dental treatment. I hereby authorize Paxton Family Dental to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page is correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

**Patient/Responsible Party Signature: Date:**

**Medical History**

**Please check the following for allergies:**

Latex Penicillin/Amoxicillin Erythromycin Tetracycline Aspirin Codeine Iodine

Sulfa Percodan Valium Acrylic Metals Dental Anesthetic Other:

**Please check any of the following symptoms or conditions that you have or have had in the past.**

AIDS/HIV InfectionADHD Alcohol/Drug Addiction Allergies Alzheimer’s

 Anemia Arthritis Artificial Joints (Date Placed: ) Asthma Autism

 Back Pain Bruise Easily Previous Bacterial Endocarditis Cancer Chemotherapy

 Diabetes/Hypoglycemia Difficulty Swallowing Dizziness/Fainting Down Syndrome

 Easily Winded Emphysema Epilepsy Excessive Bleeding Glaucoma Hemophilia

 Hepatitis A, B or C High Blood Pressure Kidney Disease Liver Disease Loss of Hearing

 Low Blood Pressure Nervousness/Depression Pacemaker Phen Fen (1 + month)

 Psychiatric Care Radiation Respiratory Problems Rheumatic Fever Scarlet Fever

 Seizures Thyroid Disease Tuberculosis Ulcers **Are you on blood thinners?** Y N

**Please list any heart conditions:**

**Please list any surgeries you have had:**

**Are you under a Physicians care?** Y N If yes what for:

**Please list or provide a list of all medications you are taking:**

**For Women Are You:** Pregnant? Y N Nursing? Y N Taking Birth Control? Y N

**\*NOTE: If you are pregnant you will need a written note from your OBGYN prior to being seen.**

**Dental History**

**Do you have or have had any of following?** Dentures Partials Braces Periodontal (gum) treatments

**Please check any of the following problems that apply to you.**

 Sensitivity to hot/cold/sweet Headaches, earaches, neck pain Jaw joint pain Bad breath

 Loose, tipped or shifting teeth Bleeding, swollen, irritated gums Grinding or clenching teeth

**Reason for your visit today:**

**Do you smoke or chew Tobacco?**  Y N How much? How Long?

**If known, please list the following dates:**  Last Exam Last X-Rays

**Who was your last dentist?** Reason for leaving?

**I would like to**: Replace missing teeth Repair chipped teeth Straighten teeth/Close spaces Whiten teeth

**Patient/Guardian Signature: Date:**

**Doctors Signature: Date:**