# Welcome to Macadam Dental

We are complimented that you have selected us to provide dental care for you and your family.
Please review this print-out and sign the Consent for Treatment on page 2.

## PATIENT INFORMATION

E-mail: Date Submitted:

Patient Name:

Address:

City: State: Zip:

How long at this address:

Home Phone: Cell Phone:

Birthdate: Social Security Number:

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

Employer: Work Phone:

Occupation: Time here:

Spouse Name: Spouse Birth date:

Spouse Social Security Number: Spouse Employer:

Spouse Occupation: Time here:

How did you learn about our office:

If you were referred by someone, whom may we thank?

## RESPONSIBLE PARTY / BILLING INFORMATION

Responsible Party Name:

Address:

City: State: Zip:

How long at this address:

Home phone:

Social Security Number:

Relationship to patient:

Employer: Occupation:

Spouse Name: DOB:

Spouse Social security Number: Employer:

Spouse Occupation:

## INSURANCE INFORMATION

Insured's Name:

SSN / ID#:

Group Number:

Address:

City: State: Zip:

Do you have dual coverage? ☐ yes ☐ No

Insured's Name:

SSN / ID#:

Group Number:

Address:

City:

Patient Name: Date Submitted:

## CONSENT FOR TREATMENT

I hereby authorize Macadam Dental to administer any treatment and to perform such as x-rays, anesthetics, and dental procedures as may be deemed necessary or advisable in the diagnosis and treatment of my dental condition.

I authorize release of any information releasing to this claim. I realize that I am ultimately responsible for all costs of dental treatment.

I hereby authorize my insurance benefits to be paid directly to Macadam Dental.

Date: _____ Signature (patient or parent for minor) _____

After initial x-rays and examination, we will give you an estimate of fees to cover your treatment. At that time financial arrangements will be made before treatment is rendered.

Preferred Method of Payment: ____ Cash _____ Check _____ Bankcard

## MEDICAL HISTORY

To the best of my knowledge, all of the following answers are correct. If my health or medications change, I will inform Macadam Dental at my next appointment.

Date: _____ Signature (patient or parent for minor) _____

**Are you under a physician's care now?** ☐ **Yes** ■ **No**
**If yes, please explain:**

**Have you ever been hospitalized or had a major operation?** ■ **Yes** ☐ **No**
**If yes, please explain:**

**Are you taking any medications, pills or drugs?** ☐ **Yes** ☐ **No**
**If yes, please explain:**

**Do you take, or have you taken, Phen-Fen or Redux?** ☐ **Yes** ☐ **No**

**Are you on a special diet?** ☐ **Yes** ☐ **No**

**Do you use tobacco?** ☐ **Yes** ☐ **No**

**Do you use controlled substances?** ☐ **Yes** ☐ **No**

**Pregnant / Trying to get pregnant?** ☐ **Yes** ☐ **No**

**Currently nursing?** ☐ **Yes** ☐ **No**

**Taking oral contraceptives?** ■ **Yes** ☐ **No**

**Have you ever had an adverse reaction or allergies to any mediation or substance? (Please check if allergic.)**

| | | | |
|---|---|---|---|
| ☐ **Acrylic** | ☐ **Iodine** | ☐ **Nitrous Oxide** | ☐ **Tetracycline** |
| ☐ **Aspirin** | ☐ **Latex** | ☐ **Novocaine** | ☐ **Valium** |
| ☐ **Codeine** | ☐ **local Anesthetics** | ☐ **Penicillin** | ☐ **Xylocaine** |
| ☐ **Erythromycin** | ☐ **Metal** | ☐ **Sulfa Drugs** | |

**Others:**

**Have you ever had any of the following? (Please check all that apply)**

| | | |
|---|---|---|
| ☐ **Anemia** | ☐ **Frequent Diarrhea** | ☐ **Mitral valve Prolapse** |
| ☐ **Arthritis or Gout** | ☐ **Frequent Headaches** | ☐ **Parathyroid Disease** |
| ☐ **Artificial Joint** | ☐ **frequent Urination** | ☐ **Psychiatric Care** |
| ☐ **Asthma** | ☐ **Genital Herpes** | ☐ **Radiation Treatments** |
| ☐ **Blood Transfusion** | ☐ **Glaucoma** | ☐ **Recent Weight Loss** |
| ☐ **Blood disease** | ☐ **HIV AIDS-ARC** | ☐ **Renal Dialysis** |
| ☐ **Bruise Easily** | ☐ **Hay Fever** | ☐ **Rheumatic Fever** |
| ☐ **Cancer** | ☐ **Heart Attack/Heart Failure** | ☐ **Rheumatism** |
| ☐ **Chemotherapy** | ☐ **Heart Murmur** | ☐ **Scarlet Fever** |
| ☐ **Chest Pains** | ☐ **Heart Trouble** | ☐ **Shingles** |
| ☐ **Cold Sores/Fever Blisters** | ☐ **Heart Valve or Pacemaker** | ☐ **Sickle Cell Disease** |
| ☐ **Congenital Heart Problems** | ☐ **Hemophilia** | ☐ **Sinus Problems** |
| ☐ **Convulsions** | ☐ **Hepatitis (A)** | ☐ **Spina Bifida** |
| ☐ **Cortisone Medication** | ☐ **Hepatitis (B or C)** | ☐ **Stomach/Intestinal Disease** |
| ☐ **Currently Pregnant** | ☐ **Herpes** | ☐ **Stroke** |
| ☐ **Diabetes** | ☐ **High Blood Pressure** | ☐ **Swelling of Limbs** |
| ☐ **Dizziness or fainting** | ☐ **Hives or Rash** | ☐ **Thyroid Disease** |
| ☐ **Drug/Alcohol Addiction** | ☐ **Hypoglycemia** | ☐ **Tonsillitis** |

| | | |
|---|---|---|
| ☐ Easily Winded | ☐ Irregular Heartbeat | ☐ Tuberculosis |
| ☐ Eating Disorder | ☐ Jaw Joint Pain | ☐ Tumor or Growth |
| ☐ Emphysema | ☐ Kidney Problems | ☐ Ulcers or G.I. Problems |
| ☐ Epilepsy or Seizures | ☐ Leukemia | ☐ Venereal Disease |
| ☐ Excessive Bleeding | ☐ Liver Disease | ☐ X-ray/Chemotherapy |
| ☐ Excessive Thirst | ☐ Low Blood Pressure | ☐ Yellow Jaundice |
| ☐ Frequent Cough | ☐ Lung Disease | Do you have any condition or problem not listed |

**which we should know about? Please explain:**

**Have you ever been given antibiotics before dental treatment?** ☐ Yes ☐ No

**Have you recently consumed alcohol?** ☐ Yes ■ No

**Have you recently used recreational drugs?** ☐ Yes ☐ No

Recreational use combined with anesthesia may cause a life-threatening Emergency.

## DENTAL HISTORY

**What are your present dental concerns?**

**When was your last dental visit?** **When were your last dental x-rays?**

**When was your last cleaning?**

**Have you avoided regular dental care?** ☐ Yes ☐ No **Why?**

**Do you feel you have active decay?** ☐ Yes ☐ No **Do you experience frequent bad breath?** ☐ Yes ☐ No

**Do you feel you have gum disease?** ☐ Yes ☐ No **Have you ever had gum treatments?** ☐ Yes ☐ No

**How often do you brush?** **Floss?**

**Use other aids?**

**Are you happy with the appearance of your teeth?** ☐ Yes ☐ No

**Would you like your teeth to be Whiter?** ☐ Yes ☐ No

**What are your dental expectations?**

**Name of previous dentist:** **City:** **State:**

**How would you rate your previous dental experience?**

## NEAREST RELATIVE

**Name of nearest relative not living with you?** **Phone:**

**Address:**

**City:** **State:** **Zip:**