Medical Alert For Office Use

Thank you for visiting our office. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name ____
LAST FIRST MIDDLE INITIAL NICKNAME

Address ____
STREET

____
CITY STATE ZIP

Employer/School ______________________ Drivers License ______________________

Birth date ______________________ Height ______________ Weight ______________

√ Best Contact Home ( ) ______________________ Social Security # ______________________

Work ( ) ______________________ May we contact you at work? ❑ Yes ❑ No

Mobile ( ) ______________________ ❑ Male ❑ Female

Email ______________________

Emergency: Name ______________________ Phone ( ) ______________________

Insurance

Primary Dental Carrier

Subscriber Name ______________________ Social Security # ______________ DOB ____________

Employer ______________________ Insurance Co. ______________________

Insurance Co. Phone # ______________________ Group # ______________________

Relation to Patient ______________________ Subscriber ID# ______________________

Do you have a secondary Insurance? Yes / No

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature ______________________________________ **Date** ______________________

If Patient is Under 18

Responsible Party ______________________ Relation to Patient ______________________

Address ____
STREET

____
CITY STATE ZIP

Telephone ( ) ______________________

How Did You Hear about Us?

- ❑ Friend/Family/Colleague
  Their Name: ______________________________
- ❑ Search Engine (Gmail, Yahoo, Yelp, etc)
- ❑ YP.com
- ❑ Phone book
- ❑ Social Media(Facebook, Twitter, Instagram)
- ❑ Drove by the Office
- ❑ Know Dr. Chandler
- ❑ Know Staff Member ________________
- ❑ Insurance Listing
- ❑ Website:__________________________

Medical History and Information

Conditions

- ❑ Abnormal Bleeding
- ❑ Alcohol Abuse
- ❑ Seasonal Allergies
- ❑ Anemia
- ❑ Angina Pectoris
- ❑ Arthritis
- ❑ Artificial Heart Valve
- ❑ Asthma
- ❑ Blood Transfusion
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Colitis
- ❑ Congenital Heart Defect
- ❑ Diabetes
- ❑ Difficulty Breathing
- ❑ Drug Abuse
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Facial Surgery
- ❑ Fainting Spells
- ❑ Fever Blisters
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ HIV+ Aids
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Heart Surgery
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ High Blood Pressure
- ❑ Joint Replacement
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Pace Maker
- ❑ Psychiatric Problems
- ❑ Radiation Therapy
- ❑ Rheumatic Fever
- ❑ Seizures
- ❑ Sexually Transmitted Disease
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Ulcers

Allergies

- ❑ Valium, Triazolam
- ❑ Codeine
- ❑ Dental Anesthetics
- ❑ Erythromycin
- ❑ Latex
- ❑ Metals
- ❑ Penicillin
- ❑ Sulfa
- ❑ Aspirin

Other ________________
____

Y N
❑ ❑ Do you Smoke or use Tobacco?

If Female
Y N
❑ ❑ Are you taking birth control pills?
❑ ❑ Are you pregnant?
If yes, # of weeks _____
Due Date:_____________
❑ ❑ Are you nursing?

Please list any medications you are currently taking:____
____

Are you taking any type of blood thinning medication?: **Yes/No** (please list below)
____

How long has it been since your last dental visit/cleaning? ______________________________

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

______________________________________ ______________________
PATIENT or PARENT/GUARDIAN SIGNATURE DATE