METROPOLITAN
DENTAL

Patient Information

Date: _____

Patient Name: _____

I prefer to be called: _____

Parent/Guardian names (if minor): _____

_____

Address: _____

City: _____State: _____Zip Code: _____

Birth Date: _____ Age: _____ Gender: M / F

Single □ Married □ Widowed□ Separated □ Divorced □

Patient SS#:_____

Email:_____

Employer: _____

Dental Insurance

Insurance Co. _____

Group #: _____ ID#: _____

Who is responsible for this account? _____

SS#/ID#: _____ Birth Date: _____

Relationship to Patient: _____

Is patient covered by additional **dental** insurance? Yes /No

Subscribers Name:_____

Insurance Co: _____

SS#/ID#: _____ Birth Date:_____

Phone Numbers

Home Phone: _____

Wireless Phone: _____

Work Phone: _____

Confirmation method: **Home Cell E-Mail Text**

I was **referred** by: _____

Physician's Name: _____

Physician's Phone: _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name: _____

Relationship: _____

Phone Number: _____

Assignment and Release

I certify that I (or my dependent) have insurance coverage or have informed the office otherwise. I hereby authorize payment directly to **Metropolitan Dental** for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on behalf of my dependents.
I authorize the above doctor and/or provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature Date

_____
Relationship to Minor (if applicable)

Your Medical/Dental History is important to your dental health and treatment. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to answer the following questions so we can better assist you with your dental needs.

1. Are you currently under medical treatment? Yes □ No □

Please explain: _____

2. Have you ever had any serious illnesses or operations? Yes□ No □ If yes, please explain:_____

_____

3. Are you currently taking any prescription or over the counter drugs? Yes □ No □

Please list all, including vitamins, and supplements:

_____

_____

_____

4. Do you experience dry mouth? ..... Yes □ No □

5. Do you smoke or use other tobacco products? Yes □ No □

6. Do you wear contact lenses? ..... Yes □ No □

7. Have you had any allergic reactions to the following:

a. Local Anesthetics (ie. Novocaine) .....Yes □ No □

b. Sulfa Drugs .....Yes □ No □

c. Barbiturates (sleeping pills) ..... Yes □ No □

d. Sedatives ..... Yes □ No □

e. Iodine ..... Yes □ No □

f. Aspirin ..... Yes □ No □

g. Metals ..... Yes □ No □

h. Latex..... Yes □ No □

i. Antibiotics _____

j. Other _____

8. Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? .....Yes □ No □

9. For Women only:

a. Are you pregnant? ..... Yes □ No □

b. Are you nursing? ..... Yes □ No □

c. Are you taking birth control? ..... Yes □ No □

1. Please mark (x) all that **apply:**

AIDS/ HIV.....	Yes □
Anemia	Yes □
Arthritis, Rheumatism	Yes □
Artificial Heart Valves	Yes □
Artificial Joints/ Bones	Yes □
If yes, date: _____	
Asthma	Yes □
Back Problems	Yes □
Bleeding abnormally.....	Yes □
Blood Disease	Yes □
Psychiatric Care.....	Yes □
Cancer- Type_____	Yes □
Cardiovascular disease	Yes □
Chemical Dependency	Yes □
Low blood pressure	Yes □
High blood pressure	Yes □
Pacemaker	Yes □
Hemophilia	Yes □
Autoimmune disease	Yes □
Emphysema	Yes □
Sinus Trouble	Yes □
Tuberculosis	Yes □
Chronic Pain	Yes □
Diabetes- Type I or II (circle)	Yes □
Gastrointestinal disease	Yes □
Ulcers	Yes □
Thyroid problems	Yes □
Stroke	Yes □
Glaucoma	Yes □
Hepatitis- Type_____	Yes □
Jaundice or liver disease	Yes □
Epilepsy	Yes □
Fainting spells or seizures	Yes □
Nervous/ Anxious	Yes □
Severe headaches/migraines	Yes □
Persistent swollen glands	Yes □
Sexually transmitted disease	Yes □
Sleep apnea/ use a CPAP	Yes □

2. Do you have any disease, condition or problem not listed above that you think we should know about?

_____

3. What would you like to change most in the appearance of your teeth? _____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand that my dentist and his/her staff will rely on this information for treating me and therefor the importance of a truthful health history. I will not hold my dentist, or any other member of his/her staff, responsible for any action they do or do not take because of errors or omissions I may have made on the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____