ACADEMY DENTAL ASSOCIATES

10101 Academy Road
Philadelphia, PA 19114

ACCT # _____

MEDICAL ALERT FOR OFFICE USE:

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

PATIENT INFORMATION

DATE _____

NAME _____
LAST FIRST MIDDLE INITIAL NICKNAME

ADDRESS _____
STREET APT. #

_____
CITY STATE ZIP

EMPLOYER _____ DRIVER'S LICENSE _____

BIRTHDATE _____ HEIGHT _____ WEIGHT _____

TELEPHONE
HOME _____ CELL _____ SOCIAL SECURITY NUMBER _____

BUSINESS _____ E-MAIL ADDRESS _____

EMERGENCY: NAME _____ PHONE _____

INSURANCE

PRIMARY CARRIER
COMPANY NAME _____

ADDRESS _____
STREET CITY STATE ZIP

POLICY NUMBER _____ TELEPHONE _____

SECONDARY CARRIER
COMPANY NAME _____

ADDRESS _____
STREET CITY STATE ZIP

POLICY NUMBER _____ TELEPHONE _____

AUTHORIZATION

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 are correct to the best of my knowledge.

★SIGNATURE _____ DATE _____

OTHER INFORMATION

SPOUSE NAME _____
LAST FIRST MIDDLE INITIAL

ADDRESS _____
STREET APT. #

_____
CITY STATE ZIP

EMPLOYER _____ DRIVER'S LICENSE _____

BIRTHDATE _____

TELEPHONE
BUSINESS _____ SOCIAL SECURITY NUMBER _____

★HOW DID YOU HEAR ABOUT US? _____

What is the reason for today's visit? _____

Do you have any questions or concerns we can help you with today? _____

_____

Do you *love* your smile? _____

Is there anything you would like to change? _____

Why did you leave your last dentist? _____

What did you like *most* about your last dentist? _____

What did you like *least* about your last dentist? _____

MEDICAL HISTORY AND INFORMTION

Do you have or ever had?

- ❑ Arthritis
- ❑ Asthma
- ❑ Cancer
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Heart Murmur
- ❑ Heart Problem
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Jaundice
- ❑ Kidney Problems
- ❑ Low Blood Pressure
- ❑ Rheumatic Fever
- ❑ Sexually Transmitted Diseases
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Other _____

Are you allergic to?

- ❑ Aspirin
- ❑ Barbiturate
- ❑ Codeine
- ❑ Penicillin
- ❑ Other _____

Are you currently under the care of a physician?

❑ YES ❑ No

Please explain _____

_____

Female Patients: Are you pregnant?

❑ YES ❑ No

If yes, due date _____

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's Signature Date

If patient is child or requires a guardian:

_____ _____

Parent or Guardian's Signature Date