Welcome to 50 Commerce Dental Center!

Patient Information

Patient Name _____ Today's Date _____
Home Address _____ Date of Birth _____
_____ Home Phone _____
_____ Social Security#_____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____

Insurance Information

Name of Insured_____ Relationship to Patient _____
Birthdate _____ SS#/SIN_____ Date Employed _____
Name of Employer_____ Union or Local #_____ Work Phone_____
Address of Employer _____ City _____State_____ Zip code_____
Insurance Company _____ Group # _____Policy/ ID#_____

Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" Response.

- ☐ Allergy – Aspirin
- ☐ Allergy – Latex
- ☐ Anemia
- ☐ Blood Disease
- ☐ Epilepsy
- ☐ Head Injuries
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Ulcers
- ☐ Allergy – Codeine
- ☐ Allergy – Other
- ☐ Arthritis
- ☐ Cancer
- ☐ Excessive Bleeding
- ☐ Heart Disease
- ☐ HIV
- ☐ Mental Disorders
- ☐ Pregnancy
- ☐ Rheumatism
- ☐ Stomach Problems
- ☐ Venereal Disease
- ☐ Allergy – Erythro
- ☐ Allergy – Penicillin
- ☐ Artificial Joints
- ☐ Diabetes
- ☐ Fainting
- ☐ Heart Murmur
- ☐ Jaundice
- ☐ Nervous Disorders
- ☐ Radiation Treatment
- ☐ Sinus Problems
- ☐ Tuberculosis
- ☐ Other
- ☐ Allergies
- ☐ Allergy – Hay Fever
- ☐ Allergy – Sulfa
- ☐ Asthma
- ☐ Dizziness
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Respiratory Problems
- ☐ Sleep Apnea
- ☐ Tumors

- ☐ Ever been hospitalized (illness or injury)
- ☐ Taking medication for weight control (ex. Fen-Phen)
- ☐ Subject to frequent headaches
- ☐ FEMALE: Taking birth control pills
- ☐ Presently being treated for any other illnesses
- ☐ Taking dietary supplements
- ☐ A smoker or smoked previously
- ☐ FEMALE: Pregnant

List all medications, supplements, and/or vitamins taken within the last two years:

_____
_____

Dental Information

Date of most recent dental exam _____ Date of most recent dental x-rays_____
What is your immediate concern? _____

Personal History, Check all that apply:

- ☐ Had an unfavorable dental experience
- ☐ Had trouble getting numb
- ☐ Had/have braces, orthodontic treatment
- ☐ Had any teeth removed
- ☐ Had complications from past dental treatment
- ☐ Had any reactions to local anesthetic
- ☐ Had your bite adjusted

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I understand that I am responsible to pay 50 Commerce Dental Center for any treatment performed in this office, in case my insurance should neglect payment. I understand that I am responsible for any outstanding balance. A fee of $75 will be charged to the patient's account if cancelation notice not given 24 hours prior to the appointment. I authorize 50 Commerce Dental Center to submit dental claims to my Dental Insurance company in order to get pay for my dental treatment.

Signature: _____ **Date** _____