All Care Family Dental

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form completely. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date: _____Home Phone (____) _____Cell Phone (____)_____
Name: _____ SS#_____
Address: _____ E-Mail:_____
City: _____ State: _____ Zip: _____
Sex: __M ___F Age: _____ Birthdate: _____
__ Married ___ Widowed __ Single __ Minor __ Separated __ Divorced
Whom may we thank for referring you? _____
In case of emergency who should be notified? _____ Phone _____

Primary Insurance

Person Responsible for Account: _____
Relation to Patient: _____ Birthdate: _____ SS#: _____
Address: (if different from patient's) _____
Phone: (__) _____City: _____ State: _____ Zip: _____
Person Responsible Employed by: _____Occupation:_____
Business Address: _____ Business Phone: (__) _____
Insurance Company: _____Dental/Member Services Number_____
Subscriber #: _____ Group#: _____
Names of other dependents covered under this plan: _____

Dental History

Reason For Today's Visit: _____ Date Of Last Dental Care: _____
Former Dentist: _____ Date of last dental x-rays: _____
Address: _____

Check (✓) if you have had any of the following:

_____ Sores or growth in your mouth	_____ Sensitivity to hot	_____ Bleeding Gum
_____ Loose teeth or broken fillings	_____ Sensitivity to sweets	_____ Clicking or Popping
_____ Periodontal treatment	_____ Sensitivity when biting	_____ Grinding
_____ Food collection between teeth	_____ Sensitivity to cold	_____ Bad breath

How often do you floss? _____ How often do you brush? _____

Medical History

Physician's name: _____ Date of last visit: _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of lonimin, Adipex, Fastin(brand names of phentermine), Pondimin(fenfluramine) and Redux(dexfenfluramine).
_____ Yes _____ No

Have you had any serious illnesses or operations? ____ Yes ____No
If yes describe: _____
Have you ever had a blood transfusion? _____ Yes _____No
If yes give approximate dates: _____
(WOMEN) Are you pregnant? _____ Yes _____ No Nursing? _____ Yes _____ No
Taking birth control pills? _____Yes _____No

Please circle if you have or have had any of the following:

Anemia	**Cortisone Treatment**	**Hepatitis**	**Scarlet Fever**
Arthritis, Rheumatism	**Cough, Persistent**	**High Blood Pressure**	**Shortness of breath**
Artificial Heart Valves	**Cough up blood**	**HIV/Aids**	**Skin Rash**
Artificial Joints	**Diabetes**	**Jaw Pain**	**Stroke**
Asthma	**Epilepsy**	**Kidney Disease**	**Swelling of feet/ankles**
Back problems	**Fainting**	**Liver disease**	**Thyroid problems**
Blood disease	**Glaucoma**	**Mitral Valve prolapse**	**Tobacco habit**
Cancer	**Headaches**	**Pacemaker**	**Tonsillitis**
Chemical Dependency	**Heart Murmur**	**Radiation Treatment**	**Tuberculosis**
Chemotherapy	**Heart problems**	**Respiratory disease**	**Ulcer**
Circulatory Problems	**Hemophilia**	**Rheumatic fever**	**Venereal disease**

Other: _____

Are you taking any medications: _____?
Are you allergic to any medications: _____?

I, being the patient/parent or guardian of (the named minor/child) hereby request and authorize the dental staff to perform necessary dental services for myself or my child, including but not limited to examination, prophylaxis, X-Rays, whether or not I am present during my child/children dental appointment when the treatment is carried out.

I certify that I, and/or my dependent(s), have insurance coverage with _____
And assign directly to Dr. Vishal Patel _____ D.M.D all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

I certify that the information above is correct and complete.

_____ _____
Signature of patient, parent, guardian or personal representative Date

_____ _____
Please print name of patient, parent, guardian or personal representative Relationship to patient