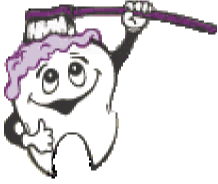

Geneva Family Dental
2631 Williamsburg Ave. Suite 201
Geneva, Il 60134
www.genevafamilydental.com

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

Patient Information

Name____Preferred Name__________________
LAST FIRST M.I.

Address____
STREET CITY STATE ZIP

Date of Birth___________________________ Male_____Female_____

Email Address_____________________________Married________Single______Other________

Phone: Home ( ) ___________________ Social Security Number__________________
Work ( )___________________ May we contact you at work? Yes____ No____
Cell ( )___________________

Emergency Name ________________________________ Phone ________________________

Subscriber of Insurance Information or Guardian Information if patient is under 18.

Subscriber Name_______________________Social Security #________________DOB_______

Employer_______________________ Ins. Co.___________________ ID # ______________

Ins. Co. Phone # _______________________ Group #____________________

Relationship to Patient_____________________ Married_________Single________Other_____

<u>Insurance Authorization Statement</u> (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__________________________

How were you referred to us? ____

What was the reason for today's visit? __________________________________

Is there anything you would like to change about your smile? ______________________

Why did you leave your last dentist? ______________________________

What did you like *most* about your last dentist? _________________________________
Have you ever had any dental complications following dental treatment? Explain.

How long since your last dental visit? ____

Medical History and Information

Conditions

___Abnormal Bleeding
___Alcohol Abuse
___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
___Previous Endocarditis
___Pacemaker
___Psychiatric Problems
___Radiation Therapy
___Rheumatic Fever
___Seizures
___STD's
___Shingles
___Sickle Cell Disease
___Stroke
___Thyroid Problems
___Tuberculosis
___Ulcers

Allergies

___Aspirin
___Codeine
___Erythromycin
___Latex
___Metals
___Penicillin
___Sulfa
___Tetracycline
___Other

Yes No
___ ___ Do you smoke?
___ ___ Dental Pre-med needed?
___ ___ Are you under the care of a Dr.?
Explain: ___________________
Physicians #____________________
Physicians Name _________________

Females Y N
___ ___ Are you taking birth control pills?
___ ___ Are you pregnant?
___ ___ Are you nursing?

Please list any medications you are currently taking:_________________________

Treatment Authorization
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 medications as indicated. I certify to the above statements, regarding my medical condition. I will notify the doctors at my next visit if I have any changes in my health. Payment for all treatment and services rendered are my responsibility.

Patient Signature____ Date _________________________
Parent/Guardian Signature____________________________________ Date__________________________