☐ ID CHECKED (RESPONSIBLE PARTY)

First Family Dental Care impressions,PC

INFORMATION (CHILD UNDER 18)

Name _____ Preferred Name_____ Sex_____

Home Address_____

Home Phone_____ Age_____ Date of Birth_____

School_____ Grade _____

How did you hear about us?_____

What is the name/phone number of the child's previous dental office?

With whom would you like the appointments confirmed?	
Mother ◯	Father ◯

How would you like us to confirm the appointments? (Please select ONE of the following)				
Text Message ◯	Email ◯	Home Phone ◯	Cell Phone ◯	Work Phone ◯

FATHER'S INFORMATION					
Is this person responsible for the account?	Yes ◉	No ◯			
Last Name			First Name		
Address			Date of Birth		
City		State		Zip	
Driver License #		SSN			
Employer		Occupation			
Email Address					
Home Phone					
Work Phone					
Cell Phone					

Marital Status:					
Single ◯	Married ◉	Separated ◯	Divorced ◯	Widowed ◯	Remarried ◯

MOTHER'S INFORMATION						
Is this person responsible for the account?	Yes ○	No ◉				
Last Name			First Name			
Address			Date of Birth			
City		State		Zip		
Driver License #		SSN				
Employer		Occupation				
Email Address						
Home Phone						
Work Phone						
Cell Phone						

Marital Status:					
Single ○	Married ○	Separated ○	Divorced ◉	Widowed ○	Remarried ○

EMERGENCY CONTACT:

Name_____Relationship_____

Home Address_____ Home Phone _____

Dental Insurance: PRIMARY			
Insurance Company		Phone #	
Group/Policy #		SS#	
Employer		Insured's Name	
Member ID#		Date of Birth	

Dental Insurance: SECONDARY			
Insurance Company		Phone #	
Group/Policy #		SS#	
Employer		Insured's Name	
Member ID#		Date of Birth	

Does the patient have any of the following habits?					
Clenching ☐	Finger Sucking ☐	Lip Biting ☐	Nail Biting ☐	Gum Chewing ☐	Ice Chewing ☐

MEDICAL HISTORY		
YES	NO	
◯	◯	Do any of the patient's teeth hurt? If yes, how long?
◯	◯	Are any of the patient's teeth sensitive to sweets or cold? If yes, how long does the sensation last?
◯	◯	Have there been any injuries to the patient's mouth or teeth? If yes, describe
◯	◯	Has the patient ever had any injury to the head and neck area? If yes, describe
◯	◯	Has the patient ever fallen and bumped their chin, or received a blow to the jaws? If yes, describe
◯	◯	Has the patient ever had any surgery in the head and neck area? If yes, describe
◯	◯	Has the patient ever had complications or illness following dental treatment? If yes, when
◯	◯	Has the patient ever been told they have periodontal disease (gum disease)? If yes, describe
◯	◯	Does it hurt to chew? If yes, where does it hurt?
◯	◯	Does the patient hear clicking, popping, or grating sounds in the jaw joints? If yes, describe
◯	◯	Has the patient ever been required to take antibiotics before visiting the dentist? If yes, why?
◯	◯	Does the patient drink bottled water?

I have reviewed the above medical and dental information, and find it accurate. If there are any later changes in my clinical history, I understand that it is my responsibility to inform Dr. Flannagan. I also give permission for Dr. Flannagan to perform a clinical examination and to make recommendations for treatment. *****I have chosen the dental provider: Dr. Flannagan, First Impressions Family Dental Care of my own free will.**

X_____(please initial)

I certify that I am covered by _____ insurance company and I assign directly to First Impressions Family Dental Care, PC all insurance benefits otherwise payable to me.

I understand I am responsible for payment of services rendered and also responsible for paying any fees, co-payment and deductible that my insurance does not cover. I also agree to pay interest at the rate of 18% APR on any balance over 90 days from the date of service. I further agree to pay any collection fees, attorney fees, and court cost should these means of collection become required. **I understand I am responsible for any collection agency fees and/or a fee for missed appointments if sufficient notice is not given. If we have not received sufficient notice, a charge may be applied to your account.** The undersigned allows First Impressions Family Dental Care, PC to use patient photos (withholding all names) as educational tools within our practice**.** I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. I acknowledge that I have received a copy of Dr. Flannagan's "Notice of Privacy Act" –HIPPA Act and Dr. Flannagan's Office Policy.

X_____ Date:_____

COMMUNICATION CONSENT:

Please list the individuals with whom we may discuss medical/financial information and indicate if we may leave a voicemail on that number with medical/financial information:			
Name	Relationship	Phone Number (with area code)	Yes, leave a voicemail
			☐
			☐
			☐

I authorize First Impressions Family Dental Care, PC to leave medical and account information pertaining to this patient's care on the voicemail for the phone numbers listed above. I also assume responsibility to notify First Impressions Family Dental Care, PC whenever this information changes. In addition to medical information, I authorize information concerning appointment confirmation, rescheduling, or staff follow up be left.

X_____ Date:_____

Time 9:33 AM | First Impressions Family Dental Care, PC | Date 4/12/2016

Medical History

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body.
Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.
Thank you for answering the following questions.

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	If yes
Do you use tobacco? (What and How Much?)	○ Yes ○ No	If yes
Do you use controlled substances?	○ Yes ○ No	

Women: Are you...

☐ Pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Acrylic ☐ Metal
☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other allergy? ○ Yes ○ No If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Anaphylaxis ○ Yes ○ No
Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No	Anemia ○ Yes ○ No
Rheumatic Fever ○ Yes ○ No	Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No
Rheumatism ○ Yes ○ No	Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No
Scarlet Fever ○ Yes ○ No	Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No	Breathing Problems ○ Yes ○ No
Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No	Bruise Easily ○ Yes ○ No
Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No	Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No
Thyroid Disease ○ Yes ○ No	Chemotherapy ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Yellow Jaundice ○ Yes ○ No	ADHD ○ Yes ○ No
Anxiety ○ Yes ○ No	Depression ○ Yes ○ No	Seasonal Allergies ○ Yes ○ No	

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____