ADVANTAGE DENTAL

___________________ PATIENT AND MEDICAL INFORMATION ___________________

Last Name: _____________________________ First Name:_________________________ M.I. _____ Sex: F____M____

Address: ____ Apt #:__________
Street City State Zip

Home Phone_________________________Cell Phone: _________________________ Date of Birth_________________

E-Mail Address:____

___________________ SUBSCRIBER INFORMATION ___________________

Last Name: _____________________________ First Name:_________________________ M.I. _____ Sex: F____M____

Address: ____ Apt #:__________
Street City State Zip

Employer: ____Work Phone:_____________________

Work Address: ____ Apt #:__________
Street City State Zip

Insurance Company Name: ____

ID #: _____________________________Group #: ___________________________ Phone #:_______________________

Name of Nearest Relative Not Living with you: ____

Address: ____ Phone #:_____________
Street City State Zip

Parent's Name (If Patient is Minor):____

Emergency Contact:___________________________________Phone:_________________Cell:____________________

Person Responsible for this Account:____

I Will Pay By: Cash:____________ Check:____________ Charge:____________ Insurance:____________

Responsible Person's SSN:___________________________________Patient SSN:__________________________________

Date of Last Dental Visit: ________________________ Purpose of Today's Visit:___________________________________

____
____
____

__________________ MEDICAL HISTORY __________________

Patient Name: ____Date:____________________

Has patient been hospitalized in the last 5 years? Yes_____ No_____ For What?______________________________
Is patient taking any medications? Yes_____ No_____ Please list:____
Physician's Name:___________________________________ Phone #:____________________________________
Date of patients last visit to the doctor? _________________________

Does patient now or has patient ever had the following: (Please Check):

Medical Conditions / History	Yes	No
Abnormal Bleeding		
Aids Yes______ No______ HIV Positive		
Anemia		
Asthma		
Diabetes		
Epilepsy		
Have you ever taken the diet drug Fen-Phen		
Heart Disease		
Heart Murmur / Mitro Valve Prolapse		
Hepatitis Date ____________________		
High Blood Pressure _________________ Low Blood Pressure __________________		
Prosthesis (i.e. Hip or Knee Replacement)		
Rheumatic Fever		
Tuberculosis		
Use any Tobacco Products		

Does patient have allergies to (write Yes or No on line provided):
_______ Local Anesthesia
_______ Metal
_______ Penicillin
_______ Latex

List patients allergies to ANY medications or drugs:
____
____

Are you pregnant? Yes _____ No _____

IN THE EVENT MY ACCOUNT BECOMES DELINQUENT, I UNDERSTAND, AND I AM RESPONSIBLE TO PAY THE ACTUAL AND REASONABLE COLLECTION CHARGES / OR ATTORNEY FEES.

Signature: ____Date:_________________________

ADVANTAGE DENTAL
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