FISHER DENTURE & DENTAL CARE

Thank You for choosing us as your dental care provider. We are committed to providing you the best possible dental care. If you have any problems or questions while completing the form below, we will be happy to help.

Patient's name _____ Date of Birth _____

Home phone _____ Mobile phone _____

Email address: _____ Marital Status:_____

Mailing address _____ City _____State _____ Zip _____

Emergency Contact:_____ Phone:_____

Relationship: _____ Date Of Last Denture: _____

How Did you hear about our office? ☐ Billboard ☐ Driving By ☐ Family/Friend ☐ Newspaper

☐ Dr. Referral (Name):_____ ☐ Other: _____

INSURANCE INFORMATION: ☐ Not covered by dental insurance

Your SS# : _____ or Member ID#_____

Dental Insurance Co._____ Group number_____

Covered by spouse's insurance? ☐ Yes ☐ no

Spouse's Name _____

Spouse's dental insurance company _____ Group number _____

Spouse's birthday _____ SS# or Member ID# _____

Have you ever had? ☐ AIDS/HIV ☐ Artificial Heart Valve ☐ Asthma ☐ Stroke ☐ Stent

☐ Artificial Heart Valve ☐ Artificial Joints, plates, or screws ☐ Blood Transfusion

☐ Chemotherapy ☐ Chest Pains ☐ Cortisone-Steroid Treatment ☐ Glaucoma ☐ Diabetes

☐ High Blood Pressure ☐ Hepatitis: A B C (Circle which type) ☐ Seizures ☐ Hay Fever

☐ Liver Disease ☐ Heart Disease ☐ Mitral Valve Relapse ☐ Pacemaker ☐ Radiation Therapy

☐ Psychiatric Treatment ☐ Rheumatic Fever ☐ Thyroid Trouble ☐ Blood Thinners/Aspirin

☐ Shortness of Breath ☐ Sinus Problems ☐ TB/Emphysema

☐ Other:_____

Allergies: ☐ NONE ☐ Aspirin ☐ Codeine ☐ Demerol ☐ Iodine ☐ Latex ☐ Morphine

☐ Novocain ☐ Sulfa ☐ Penicillin ☐ Other: _____

Medical Information

Are you having any discomfort at this time? YES____ NO____
If yes, explain: _____
_____

Have you been hospitalized during the past two years? YES_____NO____
If yes, explain: _____
_____

List any Surgeries: _____
_____

Have you been under the care of a physician during the past two years?
If yes, Physicians Name: _____
Phone Number: _____
Explain: _____
_____

Do you take any medications of prescription drugs? YES_____ NO____
If yes, please list: _____
_____

Are you sensitive or allergic to any anesthetics? YES_____ NO____
If yes, please list: _____
_____

Do you have, or have you ever had, any disease, condition, or problem not listed?
If yes, Please explain: _____
_____

Do you use tobacco products? YES_____ NO _____ If yes, what type, and how often: _____
_____

Are you pregnant, nursing, or taking birth control pills? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Signature: _____ **Date:** _____

I consent Fisher Denture & Dental Care to share my personal information with the following: (Family/Friends/ETC.)

Name: ***Relationship:***

1._____/_____

2._____/_____

3._____/_____

4._____/_____