PARKSIDE
DENTAL HEALTH
More to smile about™

Welcome to Parkside Dental Health where you'll experience dentistry in a very different way. We've created an environment totally devoted to your smile. That means, not only the finest dental care available, but a friendly staff committed to your comfort and an atmosphere that's attractive and soothing. Please fill out this form completely and we welcome you to our office.

PATIENT INFO.

Today's Date:_____

Name:_____
LAST FIRST MI

I Prefer to be called:_____ ❑Male ❑Female

Birthdate:___/___/___ Age:____ SS#:_____

Home address: _____

_____
CITY STATE ZIP

❑Single ❑Married ❑Divorced ❑Widowed ❑Separated

Home #: (_____)_____

Work #: (_____)_____ Ext:_____

Alternate #: (_____)_____

Employer:

_____

Employer's Address:

_____

How long? _____ Occupation:_____

Where & when is the best time to reach you?

_____

Whom may we thank for referring you?

_____

Spouse's name:

_____

Other family members seen by us:

_____

Email address:_____

INSURANCE INFO.

Primary Dental Insurance

Name:_____

Address:

_____

Phone #: (_____)_____

Group # (Plan, Local Or Policy #): _____

Insured's Information:

Name:_____

Relation:_____

Birthdate:___/___/___ Age:____ SS#:_____

Employer:_____

Secondary Dental Insurance

Insurance Company's:

Name:_____

Address:

_____

Phone #: (_____)_____

Group # (Plan, Local or Policy #): _____

Insured's Information:

Name:_____

Relation:_____

Birthdate:___/___/___ Age:____ SS#:_____

Employer:_____

ACCOUNT INFO.

Person ultimately responsible for account

❑ SAME AS PATIENT

Name: _____

Relation: _____

Billing address:

_____
CITY STATE ZIP

SS #: _____

Work Phone #: _____

EMERGENCY CONTACT

Who should we contact?

_____

Relation:_____

Home #: (_____)_____

Work #: (_____)_____ Ext:_____

Who is your Medical Doctor?

_____

MD's Phone #: (_____)_____

Please continue on back

Medical & Dental Information

What brings you to the dentist today?_____

_____

Are you in pain? ❑No ❑Yes How Long?_____

Do you require pre-medication? ❑No ❑Yes ❑Don't know

Have you ever had a problem with previous dental work?

❑No ❑Yes _____

_____

When was your last exam?_____

Last dental xrays?_____

Times a day you brush?_____

Times a week you floss?_____

How would you rate your smile? (1-10)_____

What would you like to do to improve your smile?_____

_____

Please check any of the following problems:

- ❑ Lost or broken fillings
- ❑ Discomfort, clicking or popping in jaw joint
- ❑ Red, swollen or bleeding gums
- ❑ Sensitive teeth
- ❑ Broken or Chipped teeth
- ❑ Other_____
- ❑ Cold Sores or Fever blisters
- ❑ Teeth Grinding
- ❑ Bad Breath
- ❑ Stained or Discolored Teeth
- ❑ Dry Mouth
- ❑ Canker Sores

Are you currently under the care of a physician? **❑Yes ❑No**

Please Explain:_____

Do you smoke or use tobacco in any other form? **❑Yes ❑No** **If yes, how much/how long** _____

Do you have or have you ever had any of the following diseases or medical conditions?

Y N Heart Attack/Stroke	**Y N** Kidney Problems	**Y N** Cancer/Tumor	**Y N** Chemotherapy
Y N Heart Surgery	**Y N** Pacemaker	**Y N** Asthma	**Y N** Sinus Problems
Y N Heart Murmur	**Y N** Respiratory Problem	**Y N** Hepatitis	**Y N** Diabetes/Hypoglycemia
Y N Heart Disease	**Y N** Ulcer	**Y N** HIV+/AIDS	**Y N** Leukemia
Y N Rheumatic Fever	**Y N** Psychiatric Problems	**Y N** Anemia	**Y N** Arthritis/Rheumatism
Y N Mitral Valve Prolapse	**Y N** Venereal Disease	**Y N** Emphysema	**Y N** Frequent Neck Pain
Y N Artificial Valves	**Y N** Tuberculosis (TB)	**Y N** Glaucoma	**Y N** Severe Headaches
Y N Artificial Bones/Joints	**Y N** Scarlet Fever	**Y N** Chest Pain	**Y N** Seizures/Epilepsy
Y N High/Low Blood Pressure	**Y N** Back Problems	**Y N** Fainting	**Y N** Alcohol/Drug Abuse
Y N Congenital Heart Defect	**Y N** Fever Blister/Herpes	**Y N** Shingles	**Y N** Jaw Problems TMJ/TMD

Please List any other medical condition(s) you have ever had:_____

Are you allergic to any of the following? **❑ None ❑ Latex ❑ Penicillin ❑ Tetracycline ❑ Aspirin ❑ Dental Anesthetics ❑ Others:**_____

Are you taking any prescription or over-the-counter drugs? ❑ Yes ❑ No

Please list each one:_____

Have you ever taken the drug Phen-fen and/or Redux? **❑ Yes ❑ No**

For Women: **Are you taking birth control pills?** **❑ Yes ❑ No**

Are you pregnant? ❑ Yes ❑ No Week #:_____

Are you nursing? ❑ Yes ❑ No

Parkside Dental Health treats patients based on their health needs and does not make recommendations based on dental insurance companies. I understand that Parkside will help process my insurance claim, but I am ultimately responsible for payment should my insurance company fail to pay.

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status or insurance changes.

I authorize Parkside Dental Health and its staff to perform any necessary dental services that I need during diagnosis and treatment with my informed consent.

We kindly ask for a 24 hour notice should an appointment need to be rescheduled. Failure to not show or notify us for a scheduled appointment may result in a $25 cancellation fee.

Signature:_____ **Date:**_____

OFFICE USE ONLY

Doctor's Signature:_____

Medical History Update

Date:_____ **Changes:**_____ **Signature:**_____

Date:_____ **Changes:**_____ **Signature:**_____

Date:_____ **Changes:**_____ **Signature:**_____

Date:_____ **Changes:**_____ **Signature:**_____