

David S. Amid, D.D.S.

Welcome To Our Office

Your Name: _____ Today's Date: _____
Last First MI

I prefer to be called: _____ Male Female

Birthdate: ____/____/____ Age: ____ SS# _____ Single Married

Home Address: _____
Street Address Apt/Suite City State Zip

E-mail Address _____

Mobile Phone # (____) _____ Who is your current dentist? _____

(ABLE TO RECEIVE TEXT MESSAGES FOR APPOINTMENT INFORMATION AND CONFIRMATION WITHOUT CHARGES? YES / NO)

Home Phone # (____) _____ Work Phone # (____) _____

Employer / School _____ Occupation: _____

Insurance Information: Do you have dental insurance? Yes No

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's SS# _____ Insurance ID# _____

Insured's Employer: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: __ (____) _____

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

Secondary Dental Insurance: Do you have secondary dental insurance coverage? Yes No

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's SS# _____ Insurance ID# _____

Insured's Employer: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: __ (____) _____

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

In Case Of Emergency Please Call:

Name: _____ Relation: _____

Phone Number (s): _____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that the information will be held in the strictest confidence, in compliance with Federal and State policies, and it is my responsibility to inform the Dental Office of any changes to my medical status.

Signature of Patient or Guardian

Date

Payment is due in full at the time of treatment

Unless prior arrangements have been made

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance company does not cover. 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 of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company and dental health care providers.

Signature of Patient or Guardian

Date

OFFICE POLICY FOR CHANGED OR CANCELLED APPOINTMENTS:

WE REQUEST A 48 HOUR NOTICE FOR ANY CHANGE TO SCHEDULED APPOINTMENTS

DAVID S. AMID, D.D.S.

MEDICAL/DENTAL HISTORY

First Name _____ Last Name _____ Age _____

Do your gums bleed: Yes / No

Are your teeth loose? Yes / No

Are your teeth sensitive to? Sweets Cold Heat Pressure (Circle any that pertain to you)

Have you ever had any pain, clicking or popping in your jaw joints? Yes / No

Are you currently having a dental concern? Yes / No If yes, please explain _____

Do you use tobacco of any kind? Yes / No If yes, what is your daily average _____

Do you have an allergy to latex? Yes / No

Other Allergies? Yes / No If yes, please list below

Please list any MEDICINE ALLERGIES AND REACTIONS you have had:

Medication	Reaction	Medication	Reaction

DO YOU HAVE A HISTORY OF:

Artificial Joints/Valves Yes / No Heart Attack/Surgery Yes / No Hepatitis Yes / No

Abnormal bleeding Yes / No Heart Murmur Yes / No Diabetes Yes / No

Asthma/Difficulty breathing Yes / No Tuberculosis Yes / No Stroke Yes / No

High Blood pressure Yes / No Kidney Disease Yes / No Liver Disease Yes / No

AIDS or HIV positive Yes / No Hip or Knee Replacement Yes / No

Does your physician recommend antibiotic premedication for dental treatment? Yes / No If yes, please list _____

Have you ever taken Bisphosphonate medication (Fosamax, Actonel, Boniva)? Yes / No

Please list any MEDICATION(S), INCLUDING OVER-THE-COUNTER DRUGS, you currently take:

Medication	Purpose	Medication	Purpose

(Continued on other side)

Do you have a personal physician? Yes / No

Physician's Name: _____

Phone#: _____ Date of last visit: _____

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes or updates in my medical status. I give permission to obtain from my physician any additional information regarding my medical history needed to provide me with the best treatment possible.

Patient Signature _____ Date _____

If you have completed this form for another person, please print your name and sign below along with your relationship to patient.

Print _____ Relationship _____

Signature _____ Date _____

OFFICE USE ONLY

Health History Update: On a regular basis, we will be asking about any changes in your medical history

Date	Changes/Comments	Signature of Patient and Provider
____/____/____	_____	_____
____/____/____	_____	_____
____/____/____	_____	_____
____/____/____	_____	_____
____/____/____	_____	_____
____/____/____	_____	_____