

**ROYAL DENTAL
ADULT INFORMATION SHEET**

Thank you for choosing our Dental office; we will do our best to make your appointments as pleasant and convenient as possible. It is our office policy to receive payment by cash, check or credit card at the time services are rendered. If you have any questions regarding your treatment, appointments, or fees, feel free to ask. Please answer the following questions as completely as possible.

Account #: _____ **Office #:** _____

PATIENT INFORMATION

Patient's Name: _____ Social Security #: _____
Address: _____ Drivers' License #: _____
City / State / Zip: _____ Birthdate: _____ / _____ / _____
Marital Status: _____ S _____ M _____ Sep _____ D _____ W Sex (check one): _____ Male _____ Female
Occupation: _____ Home Phone: _____
Employer: _____ Mobile Phone: _____
Insurance Company: _____ Work Phone: _____
Policy #: _____ Group #: _____ Email: _____
Member ID #: _____

SPOUSE INFORMATION

Spouse Name: _____ Patient? (check one) _____ Yes _____ No
Occupation: _____ Social Security #: _____
Employer: _____ Birthdate: _____ / _____ / _____
Insurance Company: _____ Home Phone: _____
Policy #: _____ Group #: _____ Mobile Phone: _____
Member ID #: _____ Email: _____

Nearest relative not living with you: _____ Relationship: _____
Phone: _____ Address: _____

Purpose of your visit: _____

Names of family members who are patients: _____

How did you hear about our office? _____

I hereby assign all dental and medical benefits to which I am entitled to Lalji Dental P.C. A photocopy of this assignment is to be considered valid as an original. I hereby authorize said assignee to release all information to secure payment.

SIGNATURE _____ **DATE** _____

PATIENT NAME: _____ **DATE:** _____

MEDICAL HISTORY FORM

Answer the following questions by checking Yes or No, whichever applies. Your answers are for our records only and will be considered confidential.

- Yes No Are you in good health?
- Yes No Has there been any change in your health since last year?
- When was your last physical exam? (date) _____
- Yes No Are you now under the care of a physician?
- If yes, for what condition? _____
- Physician name: _____
- Address: _____
- Phone #: _____
- Yes No Have you had any serious illness or hospitalization in the past 5 years?
- Yes No Are you taking any medicine(s) including non-prescription? Please list: _____
- _____

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

- Yes No Damaged heart valves, artificial valves or murmur? (Please circle which one)
- Yes No Rheumatic Heart Disease / Rheumatic fever?
- Yes No Heart trouble, heart attack, angina, high blood pressure, stroke arteriosclerosis or any other heart condition? (Please circle which one)
- Explain:** _____
- Yes No Chest pain on exertion?
- Yes No Shortness of breath after mild exercise?
- Yes No Do your ankles swell?
- Yes No Allergy?
- Yes No Sinus trouble?
- Yes No Asthma or hay fever?
- Yes No Fainting spells or seizures?
- Yes No Diabetes? Is it under control? _____
- Yes No Hepatitis, jaundice or liver disease?
- Yes No Frequent or recurring mouth sores?
- Yes No Thyroid problems?
- Yes No Respiratory problems, emphysema, bronchitis, etc.?
- Yes No Arthritis or painful, swollen joints?
- Yes No Stomach ulcer or hyperacidity?
- Yes No Kidney trouble?
- Yes No Tuberculosis?
- Yes No Persistent cough or cough that produces blood?
- Yes No Persistent swollen neck glands?
- Yes No Low blood pressure?
- Yes No Epilepsy or neurological disorder?
- Yes No Problems with mental health?
- Yes No Cancer?
- Yes No Problems of the immune system?
- Yes No Have you had radiation therapy?
- Yes No Do you smoke or use smokeless tobacco? If so, for how long? _____
- Yes No Do you or your family have a history of oral cancer?
- Yes No Do you use alcohol?
- Yes No Have you had abnormal bleeding?
- Yes No Have you ever required a blood transfusion?
- Yes No Do you have any blood disorder such as anemia?

MEDICAL HISTORY FORM (Cont.)

Yes No Have you ever had treatment for a tumor or growth?
 Yes No Do you have any artificial implants or joints? Where? _____

Are you allergic or have you had a reaction to:

Yes No Local anesthetics
 Yes No Penicillin
 Yes No Sulfas drugs
 Yes No Other antibiotics (please list): _____
 Yes No Barbiturates or sleep pills
 Yes No Aspirin
 Yes No Iodine
 Yes No Codeine or other narcotics
 Yes No Other: _____
 Yes No Have you had any serious trouble associated with previous dental treatment?
If so, explain: _____
 Yes No Do you have any other condition or disease you think the doctor should know about? If so,
explain: _____
 Yes No Are you wearing contact lenses?
 Yes No Are you wearing removable dental appliances?

Women:

Yes No Are you pregnant? How many weeks? _____
 Yes No Do you have problems associated with your menstrual period? _____
 Yes No Are you nursing?
 Yes No Are you taking birth control pills?

Chief Dental Complaint: _____

Warning: If you are currently taking or have taken a bisphosphonate drug (such as **Fosamax, Actonel** or **Boniva**) for osteoporosis or osteopenia, be aware that there is a potential for developing osteonecrosis, a condition that results in failure to heal and can lead to other lethal complications (bone and tissue destruction, possible disfigurement). In the event that you develop osteonecrosis, you may need to be referred to a specialist or to a hospital for additional treatment. Any and all resulting treatment will be at an additional cost to the patient. IT IS EXTREMELY IMPORTANT THAT YOU INFORM YOUR DOCTOR IF YOU ARE TAKING OR HAVE TAKEN ONE OF THESE DRUGS. IT IS ALSO VERY IMPORTANT THAT YOU KEEP YOUR POSTOPERATIVE APPOINTMENTS AND INFORM THE DOCTOR IF YOU FAIL TO HEAL PROPERLY. **Warning:** Taking any antibiotic will dilute the effect of birth control pills. It is advised that you use other means of birth control.

I authorize Lalji Dental P.C. to examine my (and/or my child's) teeth and take any x-rays they deem necessary for diagnosis. I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any member of the staff responsible for errors or omissions that I may have made in the completion of this form. I understand that I am responsible for payment of any treatment rendered. All x-rays and records are property of Lalji Dental P.C.

Signature (Patient/Parent/Legal Guardian) Date

Date	Comments	Doctor's Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____