

Sonoran Sky Dental

Patient Information Full Name (*print*) _____

Address _____ City _____ State _____ ZIP _____

Home Phone (____) _____ - Cell Phone (____) _____ - Marital Status _____

S.S# _____ DOB _____ Sex _____ Height _____ Weight _____

Occupation/Employer _____ Position _____ Work Phone _____

Part time _____ Full time _____ *****Full time college students using their parents coverage must provide proof of full time student status*****

Email _____

Emergency Contact Name _____ Relationship to patient _____

Home phone _____ Cell phone _____

*How did you hear about us? Friend/Relative _____ Insurance _____ Other _____

Responsible party (Guarantor):

Relationship to Patient: _____ Name _____ DOB _____ Sex _____

Address _____ City _____ State _____ ZIP _____

Home Phone (____) _____ - Work/Cell Phone (____) _____ - S.S# _____

Email _____

Occupation/Employer _____ Position _____ Work Phone _____

Primary Dental Insurance

Subscriber's name _____ Employer _____

Insurance Company _____ DOB _____ Subscriber ID# or S.S# _____

Address _____ City _____ State _____ ZIP _____

Secondary Dental Insurance

Subscriber's name _____ Employer _____

Insurance Company _____ DOB _____ Subscriber ID# or S.S# _____

Address _____ City _____ State _____ ZIP _____

References:

- 1) Name: _____ Phone number: _____ Relationship _____
- 2) Name: _____ Phone number: _____ Relationship _____

I request that all benefits, if any, or other amounts otherwise payable to me or on my behalf for services rendered, be paid directly to the provider of services. I understand that I am financially responsible for all charges of services performed by the provider. If the insurance proceeds are insufficient to cover my obligations for services rendered, I am liable for the shortfall. I authorize the provider of services to release all information necessary to secure the payment services. Failure to provide complete information may result in receiving a bill for services rendered, I am aware that by signing below I certify that all the information is complete and correct to the best of my knowledge.

Print name: _____ Patient Signature: _____ Date: _____

Parent/Guardian:

Print name: _____ Signature: _____ Relationship to patient: _____ Date: _____

Medical history

Date _____

Please check the following you have or have had:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Ear ache | <input type="checkbox"/> Hives/ rash | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Implants _____ | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive bleeding | _____ | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Angina/ chest pain | <input type="checkbox"/> Fainting/ dizziness | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Genital herpes | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Skin sores/ blisters |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Stomach ulcers or colitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Nervous disorder | <input type="checkbox"/> Stroke (year _____) |
| <input type="checkbox"/> Bleeding problem | <input type="checkbox"/> Head injury | <input type="checkbox"/> Nervous of dentist | <input type="checkbox"/> Swelling of limbs |
| <input type="checkbox"/> Blind | <input type="checkbox"/> Headaches | <input type="checkbox"/> On dialysis | <input type="checkbox"/> Thyroid problem |
| <input type="checkbox"/> Bone plates/ screws | <input type="checkbox"/> Hearing problem | <input type="checkbox"/> Oral contraceptives | <input type="checkbox"/> Trying to get pregnant |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Heart attack/ failure | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Pain in the jaw joint | <input type="checkbox"/> Tumor or growths |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Parathyroid disease | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Bruxism | <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Wheelchair patient |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Heart valve problems | <input type="checkbox"/> Portal hypertension | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Hepatic infection | <input type="checkbox"/> Prosthetic hip or joint | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Psychiatric care | For Woman Only: |
| <input type="checkbox"/> Convulsion/ epilepsy | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Recent blood transfusion | <input type="checkbox"/> Pregnant months _____ |
| <input type="checkbox"/> Cortisone medicine | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> Nursing |
| <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> History of drug abuse | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Is there a chance you may be pregnant? |
| <input type="checkbox"/> Deaf | <input type="checkbox"/> HIV positive | <input type="checkbox"/> Rheumatic heart disease | |
| <input type="checkbox"/> Diabetes | | | |
| <input type="checkbox"/> Digestive tract ulcer | | | |

Reason for today's visit: _____

List and/or Explain Other Medical Conditions not listed above: _____

Do you have any Allergies? YES [] NO []

- | | | | |
|--|-------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Acrylic | <input type="checkbox"/> Latex | <input type="checkbox"/> Motrin | <input type="checkbox"/> Metal; type _____ |
| <input type="checkbox"/> Acetaminophen | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Lidocaine | <input type="checkbox"/> Ibuprofen |
| <input type="checkbox"/> Amoxicillin | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Tylenol | <input type="checkbox"/> Vicodin | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Other |

Are you taking any of the following? YES [] NO []

[] Aspirin/Blood thinners [] Bisphosphonate Reason: _____

Primary Physician's Name _____ Number (_____) _____

Date of last physical exam _____ Are you now under a physician's care for a particular problem? _____ Have you ever had any serious illness/ operation or hospitalization? _____ Due to pre-existing medical conditions, is pre-medication required for dental treatment? *If yes, please specify medication and its instructions*

_____ Please list all medications you are currently taking also including (Vitamin Supplements): _____

By signing below I acknowledge that I have read and understand the above medical questionnaire. That the information on this form provided is essential to determine my medical/cosmetic needs and provision of the treatment plan and that I will have the opportunity to discuss my health history with my doctor during this appointment. If any changes occur in my health/history I will report it to the office as soon as possible in writing. I acknowledge that all answers have been truthful and I will not hold any of the staff responsible for any error or omissions that I have made in the completion. I consent to the examination and/or treatment of myself and all minor children listed, to Sonoran Sky Dental personnel.

Print Name _____ Date: _____

Patient Signature _____ Relationship _____

Doctor Signature _____ Date: _____

Medical Update: I have read my Health History dated _____ and confirm that it adequately states past and present conditions.

Exception or changes _____

Patient's signature _____ Date _____ Doctor's initials _____