Limerick Dental Care

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Title_____ Last Name_____ First Name_____ MI___

Preferred Name _____ Preferred Pronouns _____

DOB____/____/_____ Gender_____ SSN_____ Marital Status_____

Home Address_____

Employer Name_____ Occupation_____

Work Address_____

Home phone #_____Cell phone #_____

May we call you at work? Y/N Work Phone #_____ E-mail Address_____

How would you like us to confirm your appointments? (circle one) E-Mail Home Phone # Cell Phone # text

In case of an emergency, please provide name and phone number of a close relative or friend not living with you:

Name_____ Relationship to patient_____ Telephone #_____

Person Responsible for Fee (if other than patient):

Name_____ SSN_____ DOB: ____/_____/__ ____

Relationship_____Address_____ Phone #_____

Date of last dental visit: _____/_____/_____ Reason for today's visit: _____

Are there any changes you would like to make to your smile? Y/N

How did you hear about our office? _____

Health Information:

Please list all medications you are currently taking (prescription and over the counter):

_____ _____ _____

_____ _____ _____

Are you currently taking Coumadin or any other blood thinners including aspirin? Y/N

Do you need antibiotic premedication prior to dental treatment? Y/N

Females: Are you currently pregnant? Y/N

Are you taking biphosphonate medication? Y/N

Are you allergic to Penicillin? Y/N Are you allergic to latex? Y/N

Please list all allergies: None or_____ _____ _____ _____

Medical History: Do you have or have you ever had any of the following:

Heart Problems Y/N please explain_____

Immuno-compromised condition Y/N please explain_____

Artificial Joints Y/N type and year placed_____

Hepatitis or Liver Disease Y/N type _____

Diabetes Y/N type_____

Cancer Y/N type_____ Radiation treatment Y/N year_____

Heart Valve Replacement	Y/N	High Blood Pressure	Y/N	Stroke	Y/N
History of infective endocarditis	Y/N	Epilepsy	Y/N	Kidney Disease	Y/N
Congenital Heart Defect	Y/N	Pacemaker	Y/N	Tuberculosis	Y/N
Pulmonary Shunt or Conduits	Y/N	Anxiety and/or Depression	Y/N	Other	Y/N

Have you been admitted to a hospital or needed emergency care during the past 2 years? Y/N

If yes, please explain_____

Have you ever had complications following dental treatment? Y/N

If yes, please explain_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at my next appointment.

X_____ Date: _____

Consent for Service

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for the payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collection from insurance companies and will credit any such collections to the patient account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

X_____ _____ _____

Date Relationship to patient

I have reviewed both sides of this sheet and all of the information is correct and complete.

Initial	Date	Initial	Date	Initial	Date	Initial	Date
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____