PATIENT PROFILE TODAY'S DATE: _________________

Edgewood Family Dentistry ♦ Stephen L. Harrington, DDS

WELCOME TO OUR OFFICE! We are committed to providing the most modern dentistry available in today's world, in a caring and comfortable environment. We appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us; we are happy to help.

Whom may we thank for referring you? ____

Why have you come to the dentist today? ____
Are you currently in pain? [ ] Yes [ ] No
Have you ever had a serious/difficult problem with previous dental work? [ ] Yes [ ] No
Your current dental health is: [ ] Good [ ] Fair [ ] Poor

ABOUT YOU

Name: ____________________________________ I prefer to be called_________________________ [ ] Male [ ] Female

[ ] Single [ ] Married [ ] Child [ ] Other Date of Birth: __/__/____ S.S.# ____________________

Spouse Name: ____ Date of Birth: __/__/____

Mailing Address: ____ City: _________________, State: _____ Zip: ________

Home Phone: (____) ______________ Cell Phone: (____) ______________ Work Phone: (____) ______________

Email: ___________________________________ Employer: ____

PERSON RESPONSIBLE FOR ACCOUNT

[} Same as above -OR- Name: _______________________________ Date of Birth __/__/____ Relation: _________

Mailing Address: ____ City: _________________, State: _____ Zip: ________

Home Phone: (____) ______________ Cell Phone: (____) ______________ Work Phone: (____) ______________

Employer: ____

DENTAL INSURANCE INFORMATION

Insurance Company: __________________________________ Phone: (___) __________ Group/Policy #: ___________

Insured's Name: __________________________________ Date of Birth: __/__/____ Relation: ____________________

Insured's S.S.#:__________________________________ Insured's Employer: __________________________________

CONSENT

All procedures will be paid for at the time of service. Our office accepts cash, personal checks, Visa, Discover, MasterCard, and CareCredit®. As a convenience to our patients with insurance, we will file the necessary forms to help you receive the benefits of your dental insurance. However, WE MAKE NO GUARANTEE OF ANY ESTIMATED COVERAGE. Please understand that your insurance policy is an agreement between you, your employer and your insurance company. I authorize release of any information relating to an insurance claim. There may be a charge for any missed appointments or appointments not cancelled 24 hours before the appointment time. I understand that I am responsible for all costs of dental treatment. I understand the financial arrangements above and agree to abide by these arrangements. Additionally, I have received a copy of this office's Notice of Privacy Practices.

♦ ***OVER*** ♦

MEDICAL HISTORY INFORMATION

Name of Physician: ____ Phone: (____) _____________________________

Do you have, or have you ever had, any of the following? Please check all that apply:

[ ] Allergies/Hay Fever
[ ] Anemia
[ ] Angina
[ ] Arthritis
[ ] Artificial Joints*
[ ] Artificial Heart Valves*
[ ] Asthma
[ ] Breathing Problems
[ ] Cancer
[ ] Chemical Dependency
[ ] Chemotherapy
[ ] Diabetes
[ ] Epilepsy/Seizures
[ ] Excessive Bleeding
[ ] Excessive Thirst
[ ] Fainting/Dizziness
[ ] Fever Blisters/Cold Sores
[ ] Frequent Cough
[ ] Glaucoma
[ ] Heart Disorder*
[ ] Heart Infection*
[ ] Heart Murmur*
[ ] Heart Pacemaker*
[ ] Heart Surgery*
[ ] Hepatitis A, B, C
[ ] High Blood Pressure
[ ] HIV/AIDS*
[ ] Jaundice
[ ] Kidney Problems
[ ] Liver Problems
[ ] Mitral Valve Prolapse*
[ ] Osteoporosis
[ ] Psychological Disorders
[ ] Rheumatic Fever*
[ ] Rheumatism
[ ] Sickle Cell Disease
[ ] Sinus Problems
[ ] Sleep Apnea
[ ] Stroke
[ ] Surgical Shunt*
[ ] Thyroid Problems
[ ] TMJ Syndrome
[ ] Tuberculosis
[ ] Ulcers
[ ] Venereal Disease

[ ] Other: ____

*This condition may require antibiotic premedication for certain dental procedures.

YES	NO	
[ ]	[ ]	Do you have any health problems that were not listed above or need further clarifications?
		If yes, explain: ____
[ ]	[ ]	Are you now under the care of a physician for a specific medical condition?
		If yes, explain: ____
[ ]	[ ]	Have you been admitted to a hospital or needed emergency care during the past two years?
		If yes, explain: ____
[ ]	[ ]	Have you ever taken Fosamax, or any other bisphosphonate?
[ ]	[ ]	Do you smoke or use tobacco in any form?
		If yes, explain: ____

WOMEN (Please check): [ ] Pregnant [ ] Nursing [ ] Prescription Birth Control

ALLERGIES:
Are you allergic to any medications or substances?
[ ] Aspirin
[ ] Erythromycin
[ ] Penicillin
[ ] Codeine
[ ] Jewelry/Metals
[ ] Tetracycline
[ ] Dental Anesthetics
[ ] Latex
[ ] Other
Please list any other drugs/materials that you are allergic to:
____
____
____

MEDICATIONS:
List any prescription and/or herbal/vitamin supplements:
____
____
____
____
____
____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dental team.

X ____ Date: _____________________________________
Signature of patient, parent/guardian

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated ______________________ and confirm that it states past and present conditions.

DATE:	EXCEPTIONS:	PATIENT'S SIGNATURE:
_____________	____	____

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