Date _____

PATIENT INFORMATION SHEET (18 Years and Above)

Patient Information

Patient's Last, First Name _____ Nickname _____ B.D. _____ Age _____

Male or Female Was patient adopted? Y or N

Patient's Address _____ City _____ Zip _____

List Family Siblings: _____

Patients Cell Phone: _____ Email: _____

Insurance/Employer Information (Whether you have insurance or not)

Insurance Carrier: _____ Subscriber Name: _____

Employer: _____ Employer Phone: _____

Dental Ins/Address: _____ Phone: _____

Group #: _____ Member ID#: _____

Person Financially responsible for account? _____

*** Mastercard/Visa, Cash, Check and Insurance are accepted for payment on your account ***

Confirming Appointments: If you need to cancel, please contact our office at least 24 hours prior to your appointment. We also offer Email and Text confirmations. Email ___ Text ___

Would you like to receive statements on your account via email? Yes OR No

Dental Information

What is the purpose of this dental visit? _____ Previous Dentist: _____

X-rays from another office? Yes OR No (If YES, they can be emailed to office@thefunkidsdentist.com.)

How did you hear about our office? _____

Patient's Medical Information

Pediatrician/Physician _____ Phone ( ) _____

Any history of the **following: (Please check if applies)**

o ADD/ADHD	o Developmentally. Delayed,	o Hydrocephaly/shunt
o Anemia	Age Level ____	o Learning Disability
o Anxiety/Depression	o Diabetes	o Liver or Kidney Problems
o Asthma	o Diagnostic	o Orthopedic Pins/Rods/Plates
o Autism/Asperger's/PDD	o Down Syndrome	o Pregnancy
o Birth Defect-Premature/Syndrome	o Eating Disorder	o Sickle Cell Disease/Trait
o Bleeding Disorder	o Epilepsy/Seizures	o Skin Problems
o Cancer	o Gastroesophageal/Acid reflux	o Sleep Apnea/Snoring/Gagging
o Cerebral Palsy	o G-Tube Feeding	o Speech Delay/Impairment
o Chronic Ear Infections	o GI Problem	o Substance Abuse
o Cleft Lip/Palate	o Hearing Loss/Deafness	o Tobacco-Smoking/chewing/Vaping
o Cystic Fibrosis	o Heart Defect/Disease	o Vision Loss/Impairment
	o HIV+/AIDS	o NONE

Allergies (including drug, environment, food): _____

Medications: _____

Hospitalizations/Surgeries : _____

Please provide details of anything noted above, and any other significant medical history:

_____

Patient Signature X_____ Date _____

Patient Information Updates (18 Years and Above)

Patient's Name _____

Has your medical history changed? **Yes** **or** **No**
Has there been a change in current medications or allergies? **Yes** **or** **No**

If **YES** to any of the above, please explain.

_____

Has your dental insurance changed? Y or N If yes, please write the current information and give your card to the Front Desk so that we may make a copy.

_____

Signature: X_____ Date _____

Patient's Name _____

Has your medical history changed? **Yes** **or** **No**
Has there been a change in current medications or allergies? **Yes** **or** **No**

If **YES** to any of the above, please explain.

_____

Has your dental insurance changed? Y or N If yes, please write the current information and give your card to the Front Desk so that we may make a copy.

_____

Signature: X_____ Date _____

Patient's Name _____

Has your medical history changed? **Yes** **or** **No**
Has there been a change in current medications or allergies? **Yes** **or** **No**

If **YES** to any of the above, please explain.

_____

Has your dental insurance changed? Y or N If yes, please write the current information and give your card to the Front Desk so that we may make a copy.

_____

Signature: X_____ Date _____