OnCall Dental™
URGENT CARE

Patient Information

LAST NAME | FIRST NAME | MIDDLE INITIAL | NICKNAME

STREET | APT # | CITY | STATE | ZIP

EMAIL ADDRESS | DATE OF BIRTH | SOCIAL SECURITY NUMBER

WORK PHONE # | MOBILE PHONE # | HOME PHONE #

EMERGENCY CONTACT NAME | EMERGENCY CONTACT PHONE # | HOW DID YOU HEAR ABOUT US?

Financial Information

METHOD OF PAYMENT: O SELF-PAY O INSURANCE O CARE CREDIT

RESPONSIBLE PARTY INFORMATION

POLICY HOLDER/NAME | DATE OF BIRTH | SOCIAL SECURITY NUMBER

INSURANCE COMPANY | EMPLOYER

INSURANCE PHONE # | I. D. # | GROUP #

Dental Information

WHAT IS THE REASON FOR TODAY'S VISIT?

HOW LONG SINCE YOUR LAST DENTAL VISIT? | LAST CLEANING? | LAST X-RAYS?

WHAT WOULD YOU LIKE TO ACCOMPLISH DURING TODAY'S VISIT?

- THE FOLLOWING CONFIDENTIAL INFORMATION IS FOR OUR RECORDS ONLY -

Medical History and Information

- CURRENTLY UNDER MEDICAL CARE | O YES | O NO

_____

IF YES, PLEASE EXPLAIN

- CURENTLY TAKING ANY MEDICATIONS | O YES | O NO

_____

IF YES, LIST MEDICATIONS | VITAMINS | SUPPLEMENTS

- DO YOU PRE-MEDICATE PRIOR TO TREATMENT | O YES | O NO

_____

IF YES, THEN WHY?

INDICATE ANY ALLERGIES YOU HAVE TO THE FOLLOWING:

O ASPIRIN O CODEINE O PENICILLIN O LATEX O LOCAL ANESTHETIC

O OTHER: _____

INDICATE ANY OF THE FOLLOWING WHICH YOU HAVE HAD:

O ASTHMA O EPILEPSY O DIABETES O HIV/AIDS O INFECTIOUS DISEASE

O HEPATITIS O STROKE O HEART PROBLEMS O HIGH BLOOD PRESSURE

O OTHER _____

FEMALE PATIENTS: _____ | _____

ARE YOU PREGNANT? IF YES, DUE DATE

Treatment Authorization

BEFORE TREATMENT IS RENDERED, ADEQUATE RADIOGRAPHS OF THE TEETH AND MOUTH MUST BE TAKEN. I AUTHORIZE AND GIVE CONSENT TO PERFORM DENTAL SERVICES AGREED BETWEEN THE DOCTOR AND PATIENT AND/OR PARENT OR GUARDIAN TO BE NECESSARY OR ADVISABLE INCLUDING THE USE OF LOCAL ANESTHESIA AND OTHER MEDICATION AS INDICATED. I CERTIFY TO THE ABOVE STATEMENTS REGARDING MY MEDICAL CONDITION.

PAYMENT FOR ALL TREATMENT AND SERVICES RENDERED ARE MY RESPONSIBILITY.

X _____ _____

PATIENT/LEGAL GUARDIAN SIGNATURE DATE