MILAN DENTAL ASSOCITAES

Responsibility and Consent Form

Today's Date_________________ Male:_____Female:______Date of Birth_______________

Patient Name:____SS#_____________________
First M. Last

Address:________________________________City:_______________State______Zip______

Home Phone No:_________Work Phone No:__________ Email________________ Cell_________

MEDICAL HISTORY

Physician Name:_______________________Phone No:________________________________

Are you presently under the care of a physician? Yes or No

Reason:____

Emergency Contact Person_______________________Phone No_________________________

Relationship to Patient________________________________

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

Anemia	Yes	No	Mitral Valve Prolapse	Yes	No
Diabetic	Yes	No	Heart Condition	Yes	No
Ulcers	Yes	No	Heart Murmur	Yes	No
Asthma	Yes	No	Rheumatic Fever	Yes	No
Epilepsy	Yes	No	Pacemaker	Yes	No
Abnormal Blood Pressure	Yes	No	Artificial Joint	Yes	No
Cancer	Yes	No	Heart Valve	Yes	No

Have You Had a Heart Attack Within the Last Six Months Yes No

Blood Pressure_______________Date____________________

HAVE YOU EVER BEEN EXPOSED TO:

Aids Virus	Yes	No	Hepatitis	Yes	No Type?__________
Venereal Disease	Yes	No	Tuberculosis	Yes	No

Date of Your Last TB Test____________________

MEDICATIONS (List medications you are currently taking)

____

Pharmacy Name:_________________________Phone No:________________________

ALLERGIES

Latex	Yes	No	Aspirin	Yes	No
Penicillin	Yes	No	Dental Anesthetic	Yes	No
Codiene	Yes	No	Any Other Drug?	Yes	No

WOMEN ONLY

Are You Pregnant? Yes No
Are You Currently taking Birth Control Pills? Yes No
(Note Antibiotics can interfere with Birth Control)

DENTAL HISTORY

Reason for Today's visit:____
Date of Last Dental Care:______________________Last X-rays________________
Name of Previous Dentist:____
How often do you brush?______________________Floss?______________________
Is there anything we should know about your teeth or previous dental treatment?
____

HAVE YOU HAD PROBLEMS WITH THE FOLLOWING:

Bad Breath	Yes No	Grinding Teeth	Yes No	Clicking/Popping Jaw	Yes No
Sensitive Hot/Cold	Yes No	Loose/Broken Teeth	Yes No	Periodontal Gum Problem Treatment	Yes No
Sores/Growths in Mouth	Yes No	Bleeding Gums	Yes No		

CONFIDENTIAL

Do You Use Tobacco? Yes No What Form Do You Use?__________________
How Much______________________________
How Long______________________________
Do You Currently Use Street Drugs? Sometimes_____Often______Never_____________
Do You Use Alcohol? Sometimes_____Often______Never_____________

How Did you Learn about our office?_______________________________________

If a Friend who may we thank?____

Do You have Dental Insurance? Yes_____ No______
If yes please complete the attached form.

The Above information is accurate and complete to the best of my knowledge. I will not hold my dentist, or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.
Date:_____________ Signature:______________________________________

Dentist Signature:____

I hereby authorize and request the performance of dental services for the above named person.
I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by his/her supervised staff for diagnostic purposes or dental treatment.

Patient/or Responsible Party:____
Signature Date

MILAN DENTAL ASSOCIATES

Insurance Information and Consent

Patient Name:________________________________Date of Birth:______________________

PRIMARY DENTAL INSURANCE COVERAGE

Insurance Co:____

Place of Employment:____

Subscriber Name:_____________________________________Date of Birth______________

Social Security No:_______________________Relationship to Patient:___________________

Group/Policy No:_______________________Contract No:_____________________________

Insurance Company Phone No:____

SECONDARY DENTAL INSURANCE COVERAGE

Insurance Co:____

Place of Employment:____

Subscriber Name:___________________________________Date of Birth_________________

Social Security No:________________________Relationship to Patient:____________________

Group/Policy No:_______________________Contract No:_______________________________

Insurance Company Phone No:____

Milan Dental Associates cannot guarantee the amount an insurance carrier will pay. Therefore, I acknowledge that I will personally be responsible for any share that the insurance carrier does not pay. I authorize payment from the insurance carrier directly to Milan Dental Associates. All copays are due at the time of service unless other arrangements are made.

Patient/or Responsible Party:____

Signature Date