Chris Furlan, DMD

First Last M

/ / Today's Date

Preferred Name

Suffix

Marital Status

/ / Date of Birth

Address

- - Social Security #

City, State, Zip, Apt.

Occupation

E-Mail

Home Phone #

Preferred appointment reminder: *Home, cell, work, text, or e-mail*

Cell Phone #

Whom may we thank for referring you? *Friend, Internet, etc.*

Work Phone #

EMERGENCY CONTACT

Emergency Contact Name

Emergency Contact Phone #

MEDICAL HISTORY

Physician's Name

Physician's Phone #

Physician's Address

Date & Reason for your last visit

Pharmacy Name & Address

Pharmacy Phone #

Please list any allergies or reactions to medications (*including local anesthesia "Novocaine*")

Please list any major operations

Please list any other known medical problems

(*For Women*) Are you Pregnant? Nursing?

Do you smoke?

If yes, how many & how long?

Please List your Current Medications:

CURRENT MEDICATIONS	REASON	DOSE

PLEASE CHECK ALL THAT APPLY:

	Y	N	Comment
Heart Murmur			
Mitral Valve Prolapse			
Rheumatic or Scarlet Fever			
Rheumatic Heart Disease			
Congenital Heart Disease			
Heat Trouble			
Heart Attack			
Angina			
Irregular Heartbeat			
Cardiac Surgery			
Pacemaker			
Heart Valve Replacement			
High / Low Blood Pressure			
Excessive Bleeding / Bruising			
Anemia			
Hemophilia			
Stroke			
Convulsions / Fainting			
Thyroid Problems			
Breathing Problems			
Emphysema			
Asthma			
Artificial Joint Replacement			
Antibiotic Premedication			
Vision Impairment / Blindness			

	Y	N	Comment
Tuberculosis			
Hay Fever / Seasonal Allergies			
Sinus Problems			
Stomach Problems / Ulcers			
Acid Reflux / GERD			
Intestinal Disease			
Diabetes			
Hepatitis or Liver Disease			
Kidney Problems / Dialysis			
Venereal Disease			
AIDS / HIV +			
Tumors / Growths			
Cancer			
Chemotherapy			
Radiation Therapy			
Arthritis / Rheumatism			
Sjogren's Disease			
Allergic to Medications			
Headaches			
Cold Sores			
Canker Sores			
Dry Mouth			
Drug / Alcohol Addiction			
Eating Disorder			
Sleep Apnea			
CPAP			

DENTAL HISTORY

Reason for your visit today ______________________

Date & Reason of your last dental appointment ______________________

Name & Location of your previous Dentist ______________________

Date of your last dental X-Rays / How many taken ______________________

	Y	N	COMMENT
Have you ever had an **allergic** reaction from a dental procedure?			
Have you ever had abnormal **bleeding** after a dental procedure?			
Have you ever felt **anxious** before / during a dental procedure?			
Are any of your teeth sensitive to **hot / cold?**			
Are any of your teeth sensitive to **sweets**?			
Are you having pain when **biting / chewing**?			
Do any of your teeth feel **loose** to you?			
Do your **gums bleed** when you brush your teeth?			
Do you / have you been told you have **Periodontal disease**?			
Do you / have you been told you have **receding gums**?			
Do you / have you been told you **clench / grind** your teeth?			
Are you / have you been told that you are a "**mouth breather"?**			
Do you wear or have a **denture or partial**?			
Do you / have you ever had **orthodontics / Invisalign**?			
Do you / have you ever had **dental implants**?			
Have you had **oral surgery** / wisdom teeth removed?			

RELEASES AND CONSENTS

WARNING: Anesthetics and other medications that may be necessary in your dental treatment may interact with prescriptions, over-the-counter drugs and medications, and illicit drugs. These interactions may be serious and fatal.

You must inform the doctor of all drugs and medications you are now taking, or have ever taken. You must also disclose if you are a recovering alcoholic or drug user. All information will be held in the strictest confidence and will not be disclosed without your prior approval.

LOCAL ANESTHESIA: there are several rare but possible risks or complications associated with local anesthesia (such as Novocaine) including but not limited to bruising, swelling, infection or discoloration at the injection site; temporary or permanent numbness and/or tingling of the lip, tongue, chin, gums, palate, cheek, pharynx or other injected tissue; spasm of the facial muscles; pain to the head, ears and/or neck; nausea; vomiting; irregular or accelerated heartbeat; cardiac arrest and/or death.

FOR FEMALE PATIENTS: Some antibiotics used in dentistry may decrease the effectiveness of birth control pills.

CONSENT: I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I consent, knowingly and voluntarily to the administration of local anesthesia with the associated risks as outlined above.

I am aware that the practice of dental medicine is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of proposed treatments and/or anesthesia.

To the best of my knowledge, the information that I have furnished in the foregoing patient registration is complete and accurate. I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payors and/or other health practitioners.

I hereby certify that I have read this patient registration that I have answered all questions to the best of my knowledge, and I agree to the terms expressed within.

SIGNATURE: ______________________________ DATE: ______/________/________

If other than patient, indicate relationship**:** ______________________________

FINANCIAL AGREEMENT

IF YOU DO NOT HAVE DENTAL INSURANCE

Payment is expected at the time of treatment unless other specific arrangements are made beforehand. For your convenience, we accept VISA and Mastercard. Payments more than thirty days past due will be assessed a finance charge of 1.25% per month. We try to keep our fees low by avoiding unnecessary finance and collection expenses. Thank you for your cooperation.

IF YOU HAVE DENTAL INSURANCE:

We will be happy to submit all necessary forms to your carrier. However, we request that you pay your estimated portion as services are rendered. Please understand that you are responsible for any portion of your fee not covered by your insurance.

DENTAL INSURANCE INFORMATION:

If you have insurance, the following release will allow for your insurance company to pay your benefits directly to this office:

I hereby authorize payment directly to this office of benefits payable to me for dental services rendered. I understand that I am financially responsible for any charges not covered by this authorization.

SIGNATURE: ____ DATE: ______/________/________

INSURANCE POLICY

Please complete the following section or provide us with a completed insurance form from your policy:

Relationship of patient to employee (check one): Self____ Spouse____ Child____

________________________________ ____

Insurance Company Insurance Company Address

____

Employee's Name

___________/____________/____________ __________-_________-____________

Employee's Date of Birth Employee's Social Sec. #

____

Employee's Address

Employer's Name: ______________________________ Group # _______________ I.D.#_______________

Employer's Address: ____

Is the patient a **full-time student**? _____ School: ______________________ City ________________________