QUANTUM DENTAL
HONEST AFFORDABLE CARE

1034 GATEWAY BLVD.
SUITE: 101
BOYNTON BEACH, FL.33426

P: 561.249.2585 F: 561.318.8040

PATIENT INFORMATION

NAME:_____ BIRTH DATE:_____ SEX:_____ AGE:_____

ADDRESS:_____ CITY:_____ ,STATE:___ ZIP:_____

HOME PHONE:_____ CELL PHONE:_____ WORK PHONE:_____

MARITAL STATUS: MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPERATED ☐ WIDOWED ☐

SOCIAL SECURITY #:_____ REFFERED BY:_____

RESPONSIBLE PARTY (IF SOMEONE OTHER THAN THE PATIENT)

NAME:_____ BIRTH DATE:_____ SEX:_____ AGE:_____

ADDRESS:_____ CITY:_____ ,STATE:___ ZIP:_____

HOME PHONE:_____ CELL PHONE:_____ WORK PHONE:_____

SOCIAL SECURITY #:_____ DRIVERS LICENSE #:_____

☐ *RESPONSIBLE PARTY* Is Also A *POLICY HOLDER FOR PATIENT*. ☐ *SECONDARY* Insurance *POLICY HOLDER*

☐ *PRIMARY* Insurance *POLICY HOLDER*

So that we may maintain the operation of our office on sound principles and to assure you and other patients of uninterrupted treatment, it is necessary for all patients to accept and adhere to definite arrangements of appointments and fees. Once you have made your appointment, please remember that this time is reserved for you. Therefore, *AT LEAST 24 HOURS NOTICE MUST BE GIVEN IF CANCELLATION IS ABSOLTELY NECESSARY, OTHERWISE YOU WILL BE CHARGED A BROKEN APPOINTMENT FEE OF $25.00 PER HALF AN HOUR. THERE WILL ALSO BE AN 18% FINANCE CHARGE ON ALL UNPAID BALANCES OVER 30 DAYS.*

SIGNATURE: _____ *DATE*: _____

IF YOU HAVE DENTAL INSURANCE PLEASE FILL OUT INFO BELOW:

NAME OF DENTAL INSURANCE : _____ GROUP # _____ ID #: _____

SUBSCRIBERS D.O.B. : _____ SUBSCRIBERS SSN #: _____ , EMPLOYER: _____

RELATIONSHIP To INSURED: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

PATIENT NAME: _____ **BIRTH DATE:** _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ YES ☐ NO If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ☐ YES ☐ NO If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐ YES ☐ NO If yes, please explain: _____

Are you taking any medication, pills or drugs ? ☐ YES ☐ NO If yes, please explain: _____

Do you take or have you taken Phen-Fen or Redux? ☐ YES ☐ NO _____

Have you ever taken Fosomax, Boniva, Actonel or any other medications containing Bisphosphonates? ☐ YES ☐ NO _____

Are you on a special diet? ☐ YES ☐ NO _____

Do you use tobacco? ☐ YES ☐ NO

Do you use controlled substances? ☐ YES ☐ NO

Women: Are you Pregnant/Trying to get pregnant? ☐ YES ☐ NO Taking oral contraceptives? ☐ YES ☐ NO Nursing? ☐ YES ☐ NO

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problem	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain:

Comments: _____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN: _____ **DATE:** _____