FIT DENTAL

Our goal is to provide you with the safest, most comfortable experience a dental office can provide. If you have any questions please do not hesitate to call us.

Patient Information

Date: _____

SS/Patient ID: _____

Patient Name (Last/ First/ M int.):

_____

Address:

_____

City: _____

State: _____ Zip: _____

Sex: ☐ Male ☐ Female Age: _____

E-mail: _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ____years

Birthdate: _____

Patient Employer/School: _____

Address: _____

_____

Spouses Name_____, DOB _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you?

_____

Dental Insurance

Who is responsible for this account? _____

Relationship to the Patient? _____

Insurance Co.: _____

Group #: _____

Is Patient covered by additional Insurance? ____ Yes, ____ No

Subscriber's name: _____

Birthdate: _____ SS#: _____

Relationship to Patient: _____

Insurance Co.: _____

Group #: _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Co.) and assign directly to Dr. Ajaipal S. Sekhon all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance I authorize the use of my signature on all insurance submissions: _____ (Initials)

Dr. Sekhon may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Printed name of above

Date: _____ Relation to Pt. _____

Phone Numbers

Home (____)_____ Work (____)_____ Ext _____, Cell Phone (____)_____

Spouse's Work (____)_____, Best Time and place to reach you _____

In Case of Emergency Contact (Specify someone who does not live in your household)

Name_____, Relationship _____

Home Phone (_____)_____ Work Phone (____)_____

FIT DENTAL

Medical History

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 medications, pills, or drugs?	___ Yes ___ No	If yes, please explain:_____
Do you take, or have you taken Phen-Fen or Redux?	___ Yes ___ No	If yes, please explain:_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	___ Yes ___ No	If yes, please explain:_____
Are you on a special diet?	___ Yes ___ No	If yes, please explain:_____
Do you use tobacco?	___ Yes ___ No	
Do you use controlled substances?	___ Yes ___ No	

For Women:

Are you trying to get pregnant?	___ Yes ___ No
Taking Oral Contraceptives?	___ Yes ___ No
Nursing?	___ Yes ___ No

Are you Allergic to the Following?

___ Aspirin ___ Penicillin ___ Codeine ___ Local Anesthetics ___ Acrylic ___Metal

___ Latex ___ Sulfa Drugs ___ Other (Please Explain) _____

Please continue and sign signature on next page (page 2)

FIT DENTAL

Medical History (Cont.)

Patient Name_____ **Birth Date**_____

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

Aids/HIV Positive __Yes __ No	Cortisone Medicine __ Yes __ No	Hemophilia __ Yes __ No	Radiation Treatments __ Yes __ No
Alzheimers 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(s) __ 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** _____

FIT DENTAL

Additional Insurance Information

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone _____

Employer Address _____

City _____ State_____ Zip _____

Insurance Company _____ Group# _____ Union or Local # _____

Address _____

City _____ State _____ Zip _____

How much is your deductible? _____

How much have you used? _____

Max Annual Benefit _____

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone _____

Employer Address _____

City _____ State_____ Zip _____

Insurance Company _____ Group# _____ Union or Local # _____

Address _____

City _____ State _____ Zip _____

How much is your deductible? _____

How much have you used? _____

Max Annual Benefit _____

SMILE SURVEY

Name:
Age:
Gender:

This survey will be used to help address any other dental issue or procedure that you may be interested in, while helping us concentrate on the subjects that interest you the most.
For each question below, circle the number to the right that best fits your opinion on the importance of the issue. Use the scale to the right to match your opinion.

Question: Are you interested in..	**Scale of Importance**				
	Not at all	**Not very**	**No Opinion**	**Some-what**	**Extremely**
Oral health, gum health, and overall health?	1	2	3	4	5
Fixing any chipped or broken teeth?	1	2	3	4	5
Cosmetics (fixing any problems regarding your smile)?	1	2	3	4	5
Implants, replacing missing teeth?	1	2	3	4	5
Straightening teeth (Invisalign, Orthodontics/Braces)?	1	2	3	4	5
Teeth Whitening?	1	2	3	4	5
Dentures (Full or Partial, Metal or non-metal)?	1	2	3	4	5
Sleep Apnea Devices?	1	2	3	4	5
Changing old fillings to new, white fillings?	1	2	3	4	5
Wisdom teeth problems?	1	2	3	4	5

Thank You!