



Tempe Dental Care

1835 E Guadalupe Rd. Ste 107
Tempe, AZ 85283

Thank you for visiting Tempe Dental Care. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name _____
LAST FIRST MIDDLE INITIAL NICKNAME

Address _____
STREET

CITY STATE ZIP

Employer _____ Driver License _____

Birth Date _____ Married Single Other

Height _____ Weight _____ Male Female

Phone: Home (_____) _____ Social Security # _____

Work (_____) _____

Cell (_____) _____ Email: _____

Emergency Contact: Name _____ Phone (_____) _____

How did you hear about us? Yellow Pages Google Yahoo DexKnows Walk in/Drive by Insurance
 Referral _____ Other _____

Insurance

Primary Dental Carrier

Subscriber Name _____ Subscriber ID # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Secondary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

The information on this page is correct to the best of my knowledge. (Sign & Date)

Signature _____ Date _____

If Patient is under 18

Responsible Party _____ Relation to Patient _____

Address _____
STREET CITY STATE ZIP

Telephone (_____) _____

Other Information

Physician's Name _____ Physician's Phone _____

Have you had a serious illness or operation? Y () N ()

If yes, please describe _____

Are you currently under physician care? Y () N ()

If yes, please describe _____

Medical History and Information

Conditions

- Abnormal Bleeding
- Alcohol Abuse
- Allergies
- Anemia
- Angina Pectoris
- Arthritis
- Artificial Heart Valve**
- Asthma
- Blood Transfusion
- Cancer
- Chemotherapy
- Colitis
- Congenital Heart Defect
- Diabetes
- Difficulty Breathing
- Drug Abuse
- Emphysema
- Epilepsy
- Facial Surgery
- Fainting Spells
- Fever Blisters
- Frequent Headaches
- Glaucoma
- HIV+ Aids
- Heart Attack**

- Joint Replacement**
- Heart Murmur**
- Heart Surgery
- Hemophilia
- Hepatitis A
- Hepatitis B
- Hepatitis C
- High Blood Pressure
- Kidney Problems
- Liver Disease
- Low Blood Pressure
- Mitral Valve Prolapse**
- Pace Maker
- Psychiatric Problems
- Radiation Therapy
- Rheumatic Fever**
- Seizures
- Sexually Transmitted Disease
- Shingles
- Sickle Cell Disease
- Sinus Problems
- Stroke
- Thyroid Problems
- Tuberculosis
- Ulcers

Allergies

- Aspirin
- Codeine
- Dental Anesthetics
- Erythromycin
- Latex
- Metals
- Penicillin
- Sulfa
- Tetracycline

Other _____

Y N

- Do you Smoke
or use Tobacco?

If Female

Y N

- Are you taking Birth
Control Pills?

- Are you pregnant?
If yes, # of weeks _____

- Are you nursing?

Please list any medications you are currently taking:

Have you EVER taken any bisphosphonates? (e.g. Fosomax, Actonel) Y () N ()

Treatment Authorization Form

The information on this page is correct to the best of my knowledge. I authorize and give consent to perform dental services agreed between 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.

PATIENTS SIGNATURE

DATE

If patient is a child or requires a guardian:

PARENT/GUARDIAN SIGNATURE

DATE