TRUSTED DENTISTRY.

Dr. Guy J. Moore & Associates

Although dental practitioners primarily treat the area in and around your mouth, your mouth is an integral part of your overall health. Health problems you may have, or medication you may be taking, could have an important interrelationship with the dentistry you receive. Please answer the following questions:

AIDS/HIV Positive	Y	N
Alzheimer's Disease	Y	N
Anaphylaxis	Y	N
Anemia	Y	N
Angina/Chest Pains	Y	N
Arthritis/Gout	Y	N
Artificial Heart Valve	Y	N
Artificial Joint	Y	N
Asthma	Y	N
Blood Disease	Y	N
Blood Transfusion	Y	N
Bruise Easily	Y	N
Cancer (or history of)	Y	N
Cold Sores/Fever Blisters	Y	N
Congenital Heart Disorder	Y	N
COPD or Emphysema	Y	N
Diabetes	Y	N
Drug Addiction	Y	N
Epilepsy/Seizures/Convulsions	Y	N
Excessive Bleeding	Y	N
Fainting Spells/Dizziness	Y	N
Frequent Headaches	Y	N
Glaucoma	Y	N
Heart Disease/Heart Attack	Y	N
Hemophilia	Y	N
Hepatitis A, B or C	Y	N
Herpes	Y	N
High Blood Pressure	Y	N
Hives, Rash or Allergies	Y	N
Hypoglycemia	Y	N
Heart Murmur/Irregular Heart	Y	N
Kidney Problems/Dialysis	Y	N
Leukemia	Y	N
Liver Disease	Y	N
Low Blood Pressure	Y	N
Lung Disease/Breathing Problems	Y	N
Pain in Jaw	Y	N
Parathyroid Disease	Y	N
Psychiatric Care	Y	N
Radiation/Chemotherapy	Y	N
Rheumatic Fever	Y	N
Shingles	Y	N
Sinus Trouble	Y	N
Stomach Disease	Y	N
Stroke	Y	N
Sleep Apnea	Y	N
Tuberculosis	Y	N
Ulcers	Y	N
Venereal Disease	Y	N
Yellow Jaundice	Y	N

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ Penicillin ☐ Latex ☐ Local Anesthetics

☐ Aspirin ☐ Acrylic ☐ Other_____

☐ Codeine ☐ Metal

PLEASE ANSWER QUESTIONS BELOW

Pregnant or Trying to get Pregnant ..... ☐ YES ☐ NO

Breastfeeding? ..... ☐ YES ☐ NO

Are you under Physician's Care now? ..... ☐ YES ☐ NO

Name and Number_____

Have you been hospitalized or had a major operation ..... ☐ YES ☐ NO

Please Explain_____

Have you had a serious head or neck injury? ..... ☐ YES ☐ NO

Please Explain_____

Do you use Tobacco/or have a history of using? ..... ☐ YES ☐ NO

Do you use a controlled substance? ..... ☐ YES ☐ NO

Do you pre-medicate prior to dental treatment? ..... ☐ YES ☐ NO

Please List Medications_____

_____

Are you taking any medication, pills or drugs? ..... ☐ YES ☐ NO

Please List Medications_____

_____

_____

_____

Have you ever had any serious illness not listed? ..... ☐ YES ☐ NO

Please List _____

_____

_____

Additional Information _____

_____

_____

_____

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

PATIENT INFORMATION

Patient ID:_____

Name
Last First Middle

Email

Address
Street City State Zip

SSN - -

Birthdate

Drivers License Number

Employer

Home Phone

Cell Phone

Work Phone

INSURANCE

Dental Insurance? YES or NO

Primary Insurance Cardholder's Name

Birthdate

SSN - -

Employer

PERSON RESPONSIBLE FOR PAYMENT (IF DIFFERENT FROM ABOVE)

Name
Last First Middle

Relationship

Address
Street City State Zip

SSN - -

Home Phone

Cell Phone

Work Phone

Birthdate

Employer

Spouse's Name

Spouse's Employer

Work Phone

EMERGENCY CONTACT INFORMATION (LOCAL FRIEND OR RELATIVE NOT LIVING WITH YOU)

Name

Relationship

Address
Street City State Zip

Primary Phone

HOW DID YOU HEAR ABOUT US

THANK YOU FOR TRUSTING US WITH YOUR CARE. PLEASE TELL US HOW YOU CHOSE US .

- ☐ Social Media
- ☐ Newspaper
- ☐ TV
- ☐ Drive By
- ☐ Our Website
- ☐ Billboards
- ☐ Event
- ☐ Walk In
- ☐ Phonebook
- ☐ Radio
- ☐ Chamber of Commerce
- ☐ Referral _____
- ☐ Other_____

FOR ALL PATIENTS • NOTIFY OF PRIVACY PRACTICES DISCLOSURE OF INFORMATION

I have received the Notice of Privacy Practices from this office. I authorize Angola Dental Center and/or Aegis Dental Group to disclose information regarding my appointments, accounts, and any other protected health information directly to me via voicemail, electronic mail or text messaging using the contact numbers and addresses I have provided. I understand that my information is protected and will not be disclosed to any other parties unless specifically requested by me.

Signature of Patient _____

Date ___/___/___

FOR ALL PATIENTS

I authorize the doctor(s) to perform any and all forms of procedures, treatment, therapy, and medication that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor(s) chooses and employs such assistant(s) as he/she deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor(s) and/or his/her staff. I understand that I am responsible for payment of all services rendered.

Signature of Responsible Party _____ **Relationship**_____

Date ___/___/___