DULAC DENTAL
Family Dentistry With a Personal Touch

WELCOME!

NAME: ____ Circle: Female Male
First MI Last

I prefer to be called:_____________________________ Birth Date:_____/_____/_____

Home Address:____City:________________________Zip: ____________

Home #:____Work #____

Cellular #:____Email: ____

Circle: Single Married Divorced Widowed Partnered Social Security #_______________________________________

EMPLOYER:________________________________Occupation: ________________________________

How long there? ____

How did you find us? Circle: Family/Friend/Co-worker________________________Internet Insurance Phonebook Magazine

Other family members seen by us: ____

RESPONSIBLE PARTY

DO YOU HAVE DENTAL INSURANCE? YES NO
DO YOU HAVE SECONDARY INSURANCE? YES NO

Are you responsible for this account? Yes No If "no", please fill out the information below.

Name of Account Holder_______

____ Address____

____ Home #____

___________________Work #__________________________ Birth Date /

___________________/______SS #_______________________Relationship to patient__________________________________

In the event of an emergency, is there someone that we could contact?

Their Name_________________________________Relation____

Work #____________________________________Home #____

CONSENT FOR TREATMENT

I give the office of DuLac Dental my consent for dental treatment completed by the dental assistants, hygienists and dentists. I understand that I have the opportunity to ask questions regarding my treatment prior to each procedure.

____ Date________________________
Signature of patient/parent if minor

DuLac Dental

ES Medhx -DuLac 9/27

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

Question					
Are you under a physician's care now?	☐ Yes	☐ No	If yes:	
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	If yes:	
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	If yes:	
Are you taking any medications, pills, or drugs?	☐ Yes	☐ No	If yes:	
Are you on a special diet?	☐ Yes	☐ No	If yes:	
Do you use tobacco?	☐ Yes	☐ No		
Do you use controlled substances?	☐ Yes	☐ No		

Women: Are you…

☐ Pregnant / Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Penicillin	☐ Codeine	☐ Acrylic	☐ Metal
☐ Sulfa Drugs	☐ Local Anesthetics	☐ Aspirin	☐ Latex
☐ Other	if yes:		

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

AIDS/HIV Positive	☐ Yes ☐ No	Alzheimer's Disease	☐ Yes ☐ No	Anaphylaxis	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Artificial Joint	☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Blood Disease	☐ Yes ☐ No
Breathing Problems	☐ Yes ☐ No	Bruise Easily	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	Chemotherapy currently	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Drug Addiction	☐ Yes ☐ No	Dry Mouth	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Heart Attack/Failure	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Heart Pacemaker	☐ Yes ☐ No
Heart Trouble/Disease	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No
Liver Disease	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Osteoporosis	☐ Yes ☐ No	Pain in Jaws	☐ Yes ☐ No	Psychiatric care	☐ Yes ☐ No	Radiation Treatment Currently	☐ Yes ☐ No
Recent Weight Loss	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No	Stomach/Intestinal Disease	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	Tumor or Growths	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Have you ever taken Fosamax, Boniva, Act	☐ Yes ☐ No						

Have you ever had any serious illness not listed ☐ Yes ☐ No If yes

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