VALLEY DENTAL

Complete Family Dentistry

4825 Commercial Drive
New Hartford, NY 13413
(315) 982–9590

Name _____ Date of Birth _____

When was your last dental visit? _____ When was your last full mouth x-ray? _____

Do you wear dentures or partials? ❒ yes------ How old are your dentures or partials? _____
❒ no------- Are you interested in dentures or partials? ❒ yes ❒ no

Are you under a physician's care? ❒ yes ❒ no

Physician's Name _____ Physician's Phone _____

List any medications you are taking:
_____
_____
_____
_____
_____
_____

Are you allergic to any of the following:
❒yes ❒no Aspirin ❒yes ❒no Erythromycin ❒yes ❒no Metals
❒yes ❒no Codeine ❒yes ❒no Jewelry ❒yes ❒no Penicillin
❒yes ❒no Dental anesthetics ❒yes ❒no Latex ❒yes ❒no Tetracycline
Other drug allergies: _____

For Women:
Are you taking birth control pills? ❒yes ❒no
Are you pregnant? ❒yes ❒no
If yes, how many weeks? _____
Are you nursing? ❒yes ❒no

Do you smoke/use tobacco? ❒yes ❒no
Do you usually take an antibiotic (premed) prior to dental treatment? ❒yes ❒no

Do you consider your health to be: ❒ Excellent ❒ Good ❒ Fair ❒ Poor

Do you or have you had any of the following? (Please check yes or no):

❒ y ❒ n	Abnormal Bleeding	❒ y ❒ n	Cancer/ Chemo.	❒ y ❒ n	Fever Blisters	❒ y ❒ n	HIV+/AIDS	❒ y ❒ n	Seizures
❒ y ❒ n	Alcohol Abuse	❒ y ❒ n	Colitis	❒ y ❒ n	Frequent Headache	❒ y ❒ n	Kidney Prob. /Dialysis	❒ y ❒ n	Shingles
❒ y ❒ n	Allergies	❒ y ❒ n	Congenital Heart defect	❒ y ❒ n	Glaucoma	❒ y ❒ n	Liver Disease	❒ y ❒ n	Sickle Cell Disease
❒ y ❒ n	Anemia	❒ y ❒ n	Cosmetic Surgery	❒ y ❒ n	Hay Fever	❒ y ❒ n	Low Blood Pressure	❒ y ❒ n	Sinus Problems
❒ y ❒ n	Angina Pectoris	❒ y ❒ n	Diabetes	❒ y ❒ n	Heart Attack	❒ y ❒ n	Mitral Valve Prolapse	❒ y ❒ n	Stroke
❒ y ❒ n	Arthritis	❒ y ❒ n	Difficulty Breathing	❒ y ❒ n	Heart Surgery	❒ y ❒ n	Pace Maker	❒ y ❒ n	Thyroid Problems
❒ y ❒ n	Artificial Bones/Joints	❒ y ❒ n	Drug Abuse	❒ y ❒ n	Hemophilia	❒ y ❒ n	Pneumocystis	❒ y ❒ n	Tuberculosis
❒ y ❒ n	Artificial Heart	❒ y ❒ n	Emphysema	❒ y ❒ n	Hepatitis A	❒ y ❒ n	Psychiatric Problems	❒ y ❒ n	Ulcers
❒ y ❒ n	Asthma	❒ y ❒ n	Epilepsy	❒ y ❒ n	Hepatitis B	❒ y ❒ n	Radiation Therapy	❒ y ❒ n	Venereal Disease
❒ y ❒ n	Blood Transfusion	❒ y ❒ n	Fainting Spells	❒ y ❒ n	High Blood Pressure	❒ y ❒ n	Rheumatic Fever	❒ y ❒ n	Yellow Jaundice

Do you have any other conditions/problems no covered above? ❒ yes ❒ no If yes, please explain:

_____

Emergency Contact: _____ Phone: _____ Relationship: _____

The above information is accurate to the best of my knowledge.

Patient's Signature _____ Date _____

Initial medical/dental health reviewed by:

Doctor Signature _____ Date _____

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Please Print

Patient's Full Name _____ Date of Birth _____
First Middle Last

Address _____City _____ State _____ Zip _____

Phone _____ Alternate/other phone _____

If patient is a minor,Parent or Guardian Name:_____
First Middle Last

Social Security # _____ Date of Birth _____ Employer_____

Email address: _____ Name any other immediate family members who should be on the same account for billing purposes: _____

How did you hear of Valley Dental? _____

Do you have dental insurance? ❒ yes ❒ no

	Primary Dental Insurance	Secondary Dental Insurance
Subscriber's name	_____	_____
Subscribers Soc.Sec.#	_____	_____
Id number	_____	_____
Subscribers date of birth	_____	_____
Relationship to subscriber	❒self ❒spouse ❒child ❒ other	❒ self ❒ spouse ❒ child ❒ other
Subscriber's employer	_____	_____
Name of insurance company	_____	_____
Phone number (insurance co.)	_____	_____

I authorize Valley Dental to perform the necessary treatment plan. Signature _____

I have received a copy of this office's Notice of Privacy Practices. Signature _____

I hereby authorize payment directly to Valley Dental. Signature _____

Payment Agreement I understand & agree that dental insurance policies are an arrangement between an insurance carrier & myself. I understand that this office will prepare any necessary forms to assist in making collection from the insurance company, if any, & that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand & agree that all services rendered to me are my financial responsibility. I understand & agree that this office, as a courtesy to me, will bill my insurance company, if any, for all services rendered to me. I understand that all co-payments/deductibles are due on the service date & agree to make such payments. I understand that if for any reason my insurance company fails to pay for any service rendered that I am personally responsible for payment & agree to make full payment within 30 days. In the event my account balance is referred to an agency or attorney for collection purposes, I agree to pay reasonable attorney's fees & any expenses or costs relating to the collection proceeding, including court costs. In the event that the patient is a minor, I am the parent and/or guardian of said patient& agree that I am responsible for all services rendered to the patient.

Signature _____ Date _____

OPTIONAL Credit Card Authorization

By signing hereunder, I authorize Valley Dental to bill my credit card account for any balance for services rendered to me.

❒ Visa ❒ MasterCard ❒ Discover ❒ Care Credit

Account Number _____Expiration Date _____

Signature _____ Date _____