ALLIANCE
Family Dental
Patrice A. Barber, DDS & Associates, PA
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Fayetteville, NC 28303
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Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to call us.

Date_____

PATIENT INFORMATION

Name _____ Birthdate _____ Social Security # _____

Address _____ City _____ State _____ Zip_____

Sex ❑ M ❑ F ❑ Married ❑ Divorced ❑ Single ❑ Separated ❑ Child

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

E-Mail _____

Employer _____ Employer Phone (_____) _____

Spouse or Parent's Name _____ Phone (_____) _____

How did you hear about us? _____

Person to contact in case of emergency _____ Phone (_____)_____

RESPONSIBLE PARTY

Name of Person _____

Relation to Patient _____

Address _____ E-mail _____

Birthdate _____ Social Security # _____

Home Phone (_____) _____ Cell Phone (_____) _____

Currently a patient in our office? ❑ Yes ❑ No

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (_____) _____

Insurance Company _____Group # _____ Ins. Phone (_____)_____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (_____) _____

Insurance Company _____Group # _____ Ins. Phone (_____)_____

DENTAL HISTORY

Reason for Today's Visit_____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays_____

Address _____

Check (X) Yes or No if you have had problems with any of the following:

Y N		Y N		Y N	
❑ ❑	Bad breath	❑ ❑	Grinding or clenching teeth	❑ ❑	Sensitivity to hot
❑ ❑	Bleeding gums	❑ ❑	Loose or broken teeth	❑ ❑	Sensitivity to sweets/sugar
❑ ❑	Clicking or popping jaw	❑ ❑	Periodontal treatment	❑ ❑	Sensitivity when biting
❑ ❑	Food collection between teeth	❑ ❑	Sensitivity to cold	❑ ❑	Mouth sores or ulcers

Level of Dental Anxiety (scale 1-10) _____ How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Phone _____ Date of Last Visit _____

Have you had any serious illnesses, operations or hospital stays? ❑ Yes ❑ No If yes, describe _____

Have you ever taken any of the group of drugs collectively referred to as Bisphosphonates for cancer treatment or osteoporosis?

(Examples are Fosamax, Actonel, Boniva, Zometa) Currently taking? _____ How long? _____

(Women) Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

Do you smoke? ❑ Yes ❑ No How much? _____ How long? _____

Check ( ) Yes or No if you have had problems with any of the following:

Y N		Y N		Y N		Y N	
❑ ❑	Anemia	❑ ❑	Circulatory Problems	❑ ❑	Hepatitis	❑ ❑	Rheumatic Fever
❑ ❑	Arthritis, Rheumatism	❑ ❑	Cortisone Treatments	❑ ❑	High Blood Pressure	❑ ❑	Scarlet Fever
❑ ❑	Artificial Heart Valves	❑ ❑	Cough, Persistent	❑ ❑	HIV/AIDS	❑ ❑	Shortness of Breath
❑ ❑	Artificial Joints	❑ ❑	Diabetes	❑ ❑	Jaw Pain	❑ ❑	Skin Rash
❑ ❑	Asthma	❑ ❑	Epilepsy/Seizures	❑ ❑	Kidney Disease	❑ ❑	Stroke
❑ ❑	Autoimmune Disease	❑ ❑	Fainting	❑ ❑	Liver Disease	❑ ❑	Swollen Feet or Ankles
❑ ❑	Back Problems	❑ ❑	Glaucoma	❑ ❑	Mitral Valve Prolapse	❑ ❑	Thyroid Problems
❑ ❑	Blood Disease	❑ ❑	Headaches	❑ ❑	Pacemaker/Heart Surgery	❑ ❑	Tonsillitis
❑ ❑	Cancer	❑ ❑	Heart Murmur	❑ ❑	Psychiatric Disorder/Care	❑ ❑	Tuberculosis
❑ ❑	Chemical Dependency	❑ ❑	Heart Problems	❑ ❑	Radiation Treatment	❑ ❑	Ulcer/Colitis
❑ ❑	Chemotherapy	❑ ❑	Hemophilia/Abnormal Bleeding	❑ ❑	Respiratory Disease	❑ ❑	Venereal Disease/STDs

MEDICATIONS

List medications you are currently taking: (include OTCs, herbals)

_____

_____

_____

_____

_____

ALLERGIES

❑ Aspirin ❑ Penicillin

❑ Codeine ❑ Sulfa

❑ Local Anesthetic ❑ Latex _____

❑ Nickel/Metals ❑ Other _____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

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.

The above named dental office 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.

_____ _____

Signature of Patient, Parent or Legal Guardian Date

_____ _____

Signature of Treating Dentist / Witness Date

Copayments are due in full at time of treatment unless prior arrangements have been approved