Thank You for choosing Delmarva Dental Services!

It is our goal to provide you with the best dental care possible. To help us meet all your dental healthcare needs, please fill out this form completely.

Date:_____ SS#:_____

Patient Information: (confidential)

Last Name:_____First Name:_____Middle Initial:_____

Preferred Name:_____Birthdate:_____Home Phone:_____

Address:_____City:_____State:_____Zip:_____

Check appropriate box: ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced

E-Mail:_____Cell Phone:_____

Occupation:_____Employer:_____

Your Spouse:

Business Address:_____Work Phone:_____

Name:_____SS#:_____Date of Birth:_____

Occupation:_____Employer:_____Work Phone:_____

Alternate person to contact in case of emergency:_____Phone #:_____

Dental Insurance Information:

Employee_____Relationship:_____Date of Birth:_____

Insurance company:_____Employer:_____

Primary Insurance:

Union or Group#:_____ID#:_____

Secondary Insurance: Employee:_____Relationship:_____Date of Birth:_____

Insurance company:_____Employer:_____

Union or Group#:_____ID#:_____

If you are a new patient, how did you hear about our office:_____

☐ Doctor
☐ Employee
☐ Facebook
☐ Internet
☐ Local Book
☐ Metropolitan
☐ WBOC TV
☐ Verizon Phonebook
☐ Talk Radio 92.5
☐ The Wave 97.1

☐ Patient (name)_____

Other:_____

How would you like your appointments confirmed? Check as many as apply.

- ☐ Home Phone
- ☐ Cell Phone
- ☐ Work Phone
- ☐ E-mail/E-mail address_____
- ☐ Text Message

May we use your photos/images for marketing purposes?_____ Signature:_____

Delmarva Dental Services will thoroughly explain all the dental treatment options, provide treatment that looks good and feels great, is long lasting and creates optimum dental health.

SECTON A:

Do you believe you are in good health: _____

Have you been hospitalized in the past 2 years? _____ If yes, specify reason: _____

Please list any prescription or non-prescription medications you are taking or have recently taken: _____

_____

Have you ever had to premedicate with antibiotics 1 hour prior to your dental appointment? _____

Do you believe you are pregnant? _____If yes, what is your due date?_____

Do your ankles swell during the day? _____

Do you use 2 or more pillows to sleep? _____

Do you smoke or use tobacco of any kind or use recreational drugs of any kind? _____

Are you currently taking Fosamax or any medication for osteoporosis? _____

SECTION B:

ALLERGIC TO	✓
Aspirin	
Avocados	
Bananas	
Codeine	
Darvon	
Demerol	
Erythromycin	
Latex	
Local Anesthetic	
Nitrous Oxide	
Novocain	
Peanuts	
Penicillin	
Percodan	
Percocet	
Scopolamine	
Sleeping Pills	
Tetracycline	
Valium	
Xylocaine	
Other	

CONDITION	Current	Prior
Acid Reflux		
Anemia		
Angina		
Artificial Heart Valve		
Asthma		
Arteriosclerosis		
Congenital Heart Lesions		
Diabetes		
Dizzy Spells		
Eating Disorder		
Epilepsy or Seizures		
Fainting		
Hearing Problems		
Heart Disease		
Heart Failure		
Hemophilia		
Hepatitis A / B / C		
High Blood Pressure		
HIV/AIDS Infection		
Joint Replacement		
Kidney Disease		

CONDITION	Current	Prior
Learning Problems		
Low Blood Pressure		
Lung Disease		
Organ Transplants		
Pacemaker		
Psychiatric Treatment		
Radiation/Chemotherapy		
Recovering AA or NA		
Rheumatism/Arthritis		
Scarlet/Rheumatic Fever		
Sickle Cell		
Sinus Trouble		
Stomach/Liver Problems		
Stroke		
Taking Blood Thinners		
Thyroid Problems		
Tuberculosis		
Tumor/Cancer		
Ulcers		
Unintentional Weight Loss/Gain		
X-ray/Cobalt Treatment		

Other Condition(s) not listed above:_____

I have none of the above conditions_____ (initial)

SECTION C: (Please read and INITIAL the following statements)

Statements below must be initialed PRIOR to your appointment. Failure to do so may result in refusal of treatment.

_____I acknowledge that if my account becomes delinquent and goes to collections, I will be charged an additional 45% of the total collection amount.

_____I acknowledge that if a check is returned from the bank, I will be charged a $25 fee.

_____I acknowledge if I cancel with less than 24 hours notice or do not show for my appointment there will be a $50 fee.

_____I understand that if I have dental insurance or obtain dental insurance in the future that Delmarva Dental Services is a non participating provider with all insurance companies.

_____I understand that I am responsible for all fees incurred by me or my dependants at Delmarva Dental Services. Any amount not paid by the insurance company will become my responsibility and I will pay the balance promptly.

_____The above medical history is complete and accurate. I have not knowingly withheld information and have had the opportunity to ask questions and receive answers regarding the medical profile.

Name: _____ ☐ **Patient** ☐ **Parent** ☐ **Guardian**

Signature: _____ **Date:** _____

SUBMIT