MARK R. PADEN, D.D.S.

CONFIDENTIAL PATIENT INFORMATION

Thank you for selecting our office! We at Mark Paden's office will strive to provide you with the best possible dental care with options to improve your smile. To help us meet all your dental needs, please fill out this form completely in ink. If you have any questions or need assistance, please feel free to ask for any help you may need and we will be happy to be of assistance.

Patient Name:

Date of Birth: SS#

Mailing Address: City: State: Zip:

Home # Work # Cell #

Email:

❑ Student Attending School ❑ Not Attending School ❑ Full Time ❑ Part Time

Name of School:

Please Check One: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Whom may we thank for referring you to our office?

In Case of Emergency Please Contact: Phone #

RESPONSIBLE PARTY (if other than patient must be parent or guardian in attendance at initial visit)

Name: Relationship to Patient: DOB:

Address: City: State: Zip:

Home # Work # Cell #

Email:

Is this person currently a patient in our office?

For your convenience we have the following methods of payment. Payment in full at each appointment.
Please check the option you prefer: ❑ Cash ❑ Check ❑ Visa ❑ Mastercard ❑ Care Credit

INSURANCE INFORMATION (please give insurance card to front desk to make a copy for our records)

Name: Relationship to Patient: DOB:

Billing Address: City: State: Zip:

Home # Work # Cell #

SS or ID# Employer:

Employer Address: City: State: Zip:

Insurance Company: Phone # Group #

Insurance Address: City: State: Zip:

Insurance billing is done as a courtesy service; all balances are the responsible party's responsibility.

PLEASE ALSO FILL OUT HEALTH HISTORY ON THE NEXT 2 PAGES WITH SIGNATURE

CONFIDENTIAL HEALTH HISTORY

Please Check the Appropriate Answers (Leave blank if you do not understand the question)

1. Is your general health good? ❑ Yes ❑ No If no, please explain: _____

2. Are you taking any medications or supplements? ❑ Yes ❑ No If yes, please list them below:

3. Are you being treated by a physician now? ❑ Yes ❑ No If yes, please explain: _____

4. Have you had problems with prior dental treatment? ❑ Yes ❑ No If yes, please explain:

Date of Last Dental Exam _____ Name of Last Dentist _____
Address and Phone of Last Dentist _____

5. Are you In pain now? ❑ Yes ❑ No If so, what is your primary concern? _____

If you are female, please answer the following:

❑ Yes ❑ No Are you taking birth control pills?
❑ Yes ❑ No Are you pregnant? If yes, # of weeks ☐
❑ Yes ❑ No Are you nursing?

Do you smoke or use tobacco?
❑ Yes ❑ No

Height: ☐
Weight: ☐

For office use only: BP ☐ / ☐ Heart Rate: ☐

CONDITIONS

❑ Yes ❑ No Abnormal Bleeding
❑ Yes ❑ No Alcohol Abuse
❑ Yes ❑ No Allergies
❑ Yes ❑ No Anemia
❑ Yes ❑ No Angina Pectoris
❑ Yes ❑ No Arthritis
❑ Yes ❑ No Artificial Bones
❑ Yes ❑ No Artificial Heart Valve
❑ Yes ❑ No Asthma
❑ Yes ❑ No Blood Transfusion
❑ Yes ❑ No Cancer - Chemotherapy
❑ Yes ❑ No Colitis
❑ Yes ❑ No Congenital Heart Defect
❑ Yes ❑ No Cosmetic Surgery
❑ Yes ❑ No Diabetes
❑ Yes ❑ No Difficulty Breathing
❑ Yes ❑ No Drug Abuse
❑ Yes ❑ No Emphysema
❑ Yes ❑ No Epilepsy
❑ Yes ❑ No Fainting Spells
❑ Yes ❑ No Fever Blisters
❑ Yes ❑ No Frequent Headaches

CONDITIONS

❑ Yes ❑ No Glaucoma
❑ Yes ❑ No Hay Fever
❑ Yes ❑ No Heart Attack
❑ Yes ❑ No Heart Surgery
❑ Yes ❑ No Hemophilia
❑ Yes ❑ No Hepatitis A
❑ Yes ❑ No Hepatitis B
❑ Yes ❑ No High Blood Pressure
❑ Yes ❑ No HIV+ AIDS
❑ Yes ❑ No Kidney Problems
❑ Yes ❑ No Liver Disease
❑ Yes ❑ No Low Blood Pressure
❑ Yes ❑ No Mitral Valve Prolapse
❑ Yes ❑ No Pace Maker
❑ Yes ❑ No Pneumocystitis
❑ Yes ❑ No Psychiatric Problems
❑ Yes ❑ No Radiation Therapy
❑ Yes ❑ No Rheumatic Fever
❑ Yes ❑ No Seizures
❑ Yes ❑ No Shingles
❑ Yes ❑ No Sickle Cell Disease
❑ Yes ❑ No Sinus Problems

CONDITIONS

❑ Yes ❑ No Stroke
❑ Yes ❑ No Thyroid Problems
❑ Yes ❑ No Tuberculosis
❑ Yes ❑ No Ulcers
❑ Yes ❑ No Venereal Disease
❑ Yes ❑ No Yellow Jaundice

ALLERGIES

❑ Yes ❑ No Aspirin
❑ Yes ❑ No Codeine
❑ Yes ❑ No Dental Anesthetics
❑ Yes ❑ No Erythromycin
❑ Yes ❑ No Jewelry
❑ Yes ❑ No Latex
❑ Yes ❑ No Metals
❑ Yes ❑ No Penicillin
❑ Yes ❑ No Tetracycline

Other

_____
_____

Are you suffering from any of the following signs or symptoms of aerosol transmissible illness? Please mark (yes) or (no) for each question:

1. Do you currently have a respiratory illness? ❑ Yes ❑ No
2. Have you had a cough for at least 3 weeks not explained by noninfectious conditions? ❑ Yes ❑ No
3. Have you had coughing fits that interfere with eating, drinking, talking or breathing? ❑ Yes ❑ No
4. In addition to cough, are you currently experiencing or experienced recently:
   a. Unexplained weight loss (more than 5 lbs) ❑ Yes ❑ No
   b. Night sweats ❑ Yes ❑ No
   c. Fever ❑ Yes ❑ No
   d. Chronic fatigue or malaise ❑ Yes ❑ No
   e. Painful, swollen salivary glands ❑ Yes ❑ No
   f. Unexpected rash ❑ Yes ❑ No
   g. Stiff neck ❑ Yes ❑ No
5. Have you been exposed to anyone with an infectious aerosol transmissible illness other than seasonal influenza? (See below for list of such illnesses, and check if exposed to any.)

❑ Any flu other than seasonal flu	❑ Smallpox	❑ Parvovirus
❑ Chickenpox	❑ Tuberculosis	❑ Pertussis (whooping cough)
❑ Shingles	❑ Diphtheria	❑ Pharyngitis
❑ Measles	❑ Meningitis	❑ Epstein-Barr virus
❑ Monkey pox	❑ Mumps	❑ Strep
❑ SARS	❑ Pneumonia	❑ Scarlet Fever

6. Do you have, or have you had any diseases or medical problems NOT listed on this form? ❑ Yes ❑ No
   If Yes, Please Explain _____
7. Have you ever been pre-medicated for dental treatment? ❑ Yes ❑ No
   If Yes, why? _____
8. Have you ever taken Fen-Phen? ❑ Yes ❑ No If yes, when? _____
9. Is there any issue or condition that you would like to discuss with the Dentist in private? ❑ Yes ❑ No

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize the dentist to contact my physician.

Physician's Name: _____ Phone Number: _____

Pharmacy of Choice: _____ Phone Number: _____

AUTHORIZATION

I certify that I, and/or my dependent(s), have insurance coverage with _____ and I assign directly to Dr. Mark Paden all insurance benefits, if any, otherwise payable to me for services rendered. 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.

I certify that I have read and understand this form. To the best of my knowledge, I have answered everything completely and accurately. I will inform Dr. Paden of any changes in my health and/or medications. I also understand that there will be a charge for failed appointments and/or canceled appointments without a 24 hour notice. Further, I will not hold Dr. Paden, or any member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____

Signature of Patient (Parent or Guardian) **Date**

_____

Signature of Dentist / Witness **Date**