Valparaiso Family Dentistry
2005 Roosevelt Road, Suite B
Valparaiso, In 46383
Phone 219-531-9293
Fax 219-531-0537

Southshore Family Dentistry
1431 Woodland Avenue
Michigan City, In 46360
Phone 219-874-7840

Southshore Family Dentistry
6629 W. U.S. Highway 30
Harvest Centre Suite 4
Crown Point, In 46307
Phone 219-865-8220

Name _____ Soc. Sec. # _____ - _____ - _____ Chart # _____

Address _____, _____, _____ Zip _____

Age _____ Birth Date _____ Sex: M F Home Phone _____ Cell Phone _____

Bus. Phone _____ E-mail _____

Occupation _____ Employer _____

In case of emergency please notify: Name _____ Phone _____

Physician _____ Address _____ Phone _____

Parent or Guardian _____ Address *(if different)* _____

Dental Insurance _____ I.D. # _____ Medicaid # _____

Secondary Dental Insurance _____ I.D. # _____

What is your present health? Good ___ Fair ___ Poor ___ Are you having pain or discomfort at this time? No ___ Yes ___

Circle any of the following which you have had or have at present:

Heart Condition	Anemia or Hemophilia	Skin Rashes or Hives	Thyroid Disease	Radiation Therapy (X-Ray, Cobalt)
Heart Attack or Stroke	Bruise Easily	Kidney Trouble	Cortisone Medicine	Chemotherapy (Cancer, Leukemia)
Heart Murmur	Shortness of Breath	Diabetes	Glaucoma	HIV Positive/AIDS
Chest Pains (Angina)	Swelling of Ankles	Sickle Cell Disease	Arthritis or Rheumatism	Venereal Disease
Heart Surgery	Artificial Joint	Liver Disease	Pain in Jaw Joints	Genital Herpes
Artificial Heart Valve	Lung Disease	Hepatitis A (infectious)	Fainting or Dizzy Spells	Cold Sores
Heart Pacemarker	Emphysema	Hepatitis B (serum)	Alcoholism	Epilepsy or Seizures
High Blood Pressure	Tuberculosis (T.B.)	Yellow Jaundice	Drug Addiction	Psychiatric Treatment
Rheumatic Fever		Blood Transfusion	Cancer or Tumor	

Circle

Do you have any diseases, conditions or problems not listed above? ..... No Yes
If yes, please explain _____

Are you presently taking any medicine or drugs? ..... No Yes
If yes, list drug, dosage, and frequency _____

Are you allergic to any medicine, drug or other substance? ..... No Yes
If yes, please list _____

Are you now, or have you been under the care of a medical doctor during the last two years? ..... No Yes
Have you ever been hospitalized or had surgery? ..... No Yes
Have you ever had a reaction to a local anesthetic? ..... No Yes
Have you ever had prolonged or unusual bleeding? ..... No Yes
Have you ever had complications or illness following dental treatment? ..... No Yes
Have you ever had an injury or trauma to your face or jaw? ..... No Yes

Comments:

Do you smoke or use smokeless tobacco? ..... No Yes
Are you nervous or concerned about having dental work done? ..... No Yes

Women: Are you pregnant now? Due date _____ ..... No Yes
Are you practicing birth control? ..... No Yes
Do you anticipate becoming pregnant? ..... No Yes
Have you had any complications or problems with a previous pregnancy? ..... No Yes

Dental treatment desired (circle):

Check up Cleaning Cavities Restored Missing Teeth Replaced
Cosmetic Bonding Teeth Extracted Complete Dentures Orthodontics
Other _____

Best time for dental Appointments

	Mon	Tues	Wed	Thurs	Fri
AM					
PM					

Can arrange anytime ☐

To the best of my knowledge all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the Doctor of Dentistry at the next appointment without fail. Your medical information may be shared with a third party if a collection issue should arise. Patient agrees to pay all costs incurred of any past due account, including court costs and reasonable attorney fees of at least $125.00. Any accounts more than 90 days shall be subject to a late charge of 1.5% per month.

Date _____ _____

Signature of Patient, Parent or Guardian