ELDERDENT PATIENT HISTORY – Please print & complete both sides of form.

Phone: 267-708-0156 Fax: 267-708-0158 Toll Free: 1-800-894-6655

Name of Facility____________________________Patient Phone #_______________
Patient Name____________________________________M__F__ Married__Widowed__
Address______________________City_______________State______ Zip________
Date of Birth__________________________Patient E-mail(if any):______________________

Responsible Party (Person responsible for this account & appointments)_________________________
Address_____________________________City______________________________
State____________ Zip________________Phone (H)____________(W)__________
Relationship to Patient____

Patient's Dental Insurance THIS IS NOT MEDICAL INSURANCE OR MEDICARE
Name, Address & Phone # of Carrier____
Name of Insured_________________________ SS#_________________DOB__________________
Group Company Name________________Plan #___________________ID#___________________

Patient Medical History
Physician Name and Phone #____
Is PatientAmbulatory__________________UsesWalker____________WheelChair____________

1. Is patient currently under medical treatment____
2. Briefly describe current health condition____
3. Do you wear: Upper Denture___ Lower Denture___Upper Partial__Lower Partial___ None____
4. Please list medications currently taken____
5. Do you smoke Y N Use controlled substances Y N Approximate Weight _______
6. Are you allergic to any of the following:

Local Anesthetics(e.g. Novocain)______	Iodine_______
Penicillin or Antibiotics______	Aspirin_______
Sulfa Drugs______	Any Metals (e.g. nickel, mercury)____________
Barbiturates_______	Latex Rubber____________
Sedatives__________	Other(please list)_______________________

6. Do you have or have you had any of the following **(Please circle correct choice)**

High Blood Pressure	Y N	Heart Disease	Y N	Low Blood Pressure	Y N
Cardiac Pacemaker	Y N	Liver Disease	Y N	Radiation Therapy	Y N
Rheumatic Fever	Y N	Heart Murmur	Y N	Hepatitis	Y N
Kidney Disease	Y N	Cancer	Y N	Mitral Valve Prolapse	Y N
Dementia	Y N	Angina	Y N	Aids or HIV	Y N
Tuberculosis	Y N	Asthma	Y N	Epilepsy/Seizures	Y N
Anemia	Y N	Stroke	Y N	Thyroid Problems	Y N
Emphysema	Y N	Glaucoma	Y N	Respiratory Problems	Y N
Leukemia	Y N	Diabetes	Y N		

Other_______________________ Joint Replacement (Year)___________

Authorization and Release

I certify that I have read and understand the above information. The above questions have been accurately answered to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me during dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to ElderDent, LLC, insurance benefits otherwise payable to me. I understand that my dental carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered. I understand that providing incorrect information can be dangerous to my health.

X **Date**

Signature of Responsible Party **(OVER)**