Fredericktown Family Dental

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(573)783-4100

Chart#:

FOR OFFICE USE ONLY

Patient Name: Last First MI

Preferred Name

Title: **Gender:** ◯ Male ◯ Female

Mr/Ms/Mrs/etc

Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date:

SS#: ___-__-____

Prev. Visit:

Email Address:

Best time to call:

Phone: Home Mobile Work Ext

Fax Other

Address: Address 1

Address 2

City State Zip Code

Employer Name:

Primary Dental Insurance

Name of Insured: Last

First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

Secondary Dental Insurance

Name of Insured:

Last

First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

Medical Infomation

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

Do you take antibiotic premedication for your dental visits? If yes, please explain.

If there have been any medical changes since your last visit with us, please list below.

List all medications, drugs, pills or herbal remedies, including regular dosages of aspirin.

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and had responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.**

Response Date: