



Borden Family Dentistry

Michael E. Borden, D.D.S.

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Today's Date _____

Patient's Name _____ SS # _____ - _____ - _____
last first mi

Address _____ Date of Birth _____
street city state zip

Home Phone (____) _____ Cell Phone (____) _____ F or M S M D W
sex marital status

Patient Employer _____ Work # (____) _____ Ext _____
Employer Address _____

Referred By _____ Date of Last Dental Visit _____

RESPONSIBLE PARTY IF DIFFERENT FROM PATIENT

Name _____ SS# _____ - _____ - _____ / _____
Address _____ Employer _____ Date of Birth _____
Phone # (____) _____ Work # (____) _____ Ext _____

Please answer the following questions by circling yes or no:

| | | | | | |
|------------------------|-----|----|------------------------------------|-----|----|
| SINUS TROUBLE | YES | NO | BLOOD TRANSFUSION | YES | NO |
| HEARING AID | YES | NO | THYROID DISEASE | YES | NO |
| HEART ATTACK OR STROKE | YES | NO | GLAUCOMA | YES | NO |
| HEART MURMUR | YES | NO | ARTHRITIS OR RHEUMATISM | YES | NO |
| ARTIFICIAL HEART VALVE | YES | NO | PAIN IN JAW JOINTS | YES | NO |
| HEART PACEMAKER | YES | NO | FAINTING OR DIZZY SPELLS | YES | NO |
| HIGH BLOOD PRESSURE | YES | NO | SWOLLEN NECK GLANDS | YES | NO |
| RHEUMATIC FEVER | YES | NO | TREATMENT FOR OSTEOPOROSIS | YES | NO |
| ANEMIA OR HEMOPHILIA | YES | NO | ALCOHOLISM | YES | NO |
| ARTIFICIAL JOINT | YES | NO | DRUG ADDICTION CHEMICAL DEPENDENCY | YES | NO |
| LUNG DISEASE | YES | NO | CANCER OR TUMOR | YES | NO |
| ASTHMA OR HAY FEVER | YES | NO | RADIATION THERAPY (X-ray, Colbalt) | YES | NO |
| KIDNEY TROUBLE | YES | NO | CHEMOTHERAPY (Cancer, Leukemia) | YES | NO |
| DIABETES | YES | NO | BACK PROBLEMS | YES | NO |
| LIVER DISEASE | YES | NO | VENEREAL DISEASE | YES | NO |
| HEPATITIS A, B or C | YES | NO | COLD SORES | YES | NO |
| PARKINSONS | YES | NO | EPILEPSY OR SEIZURES | YES | NO |
| ALZHEIMERS | YES | NO | HIV POSITIVE / AIDS | YES | NO |
| TUBERCULOSIS | YES | NO | LATEX ALLERGY | YES | NO |

Is there a specific dental problem YES NO If yes, please explain _____

Do you have any diseases, conditions or problems not listed about? YES NO If yes, please explain _____

Are you presently taking any medicine or drugs? YES NO If yes, please list drug, dosage, and frequency _____

Are you allergic to any medicine, drugs or any other substances? YES NO If yes, please list _____

Have you ever been hospitalized or had surgery? YES NO

Have you ever had a reaction to a local anesthetic? YES NO

Have you ever had uncontrolled or unusual bleeding? YES NO

Have you ever had complication or illness following dental treatment? YES NO

Have you ever had an injury or trauma to your face or jaw? YES NO

Do you smoke or use smokeless tobacco? YES NO

WOMEN: Are you or could you be pregnant? Due Date _____ YES NO

SEE OTHER SIDE

IN CASE OF EMERGENCY, CONTACT (specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

INSURANCE INFORMATION:

Insurance Company Name _____

Address _____

Phone # _____ Group # _____

Subscriber Name _____

Date of Birth _____ SS# / ID# _____

Address of Subscriber if different _____

DEMAND FORCE

We provide our patients the option to participate in our online patient communication system. Some of the features include the ability to:

- Submit Patient Satisfaction Surveys
- Refer Your Friends Online
- Request Appointments Online
- Confirm Appointments via Email
- Receive Text Message Appointments Reminders

You may opt-out of your communications at any time by clicking the unsubscribe link found in the footer of each email or by replying to a text message with 'Stop'. Standard Text Messaging rates apply.

Check here to OPT in to Text Messages
Cell # _____

Check here to OPT in to Email
Email Address _____

CONSENT TO TREAT & BILL INSURANCE:

I have read and answered the above questions to the best of my ability. I understand and agree that, (regardless of insurance coverage), I am ultimately responsible for the balance of my account for any professional service rendered. Any balance over 30 days is subject to 1½% interest charge. I hereby authorized Dr. Borden's office to furnish information to my insurance carrier concerning my illness and/pr treatment.

Signature _____ Date _____
Parents Signature (if minor) _____