Andrade Dental Family
Dr. Audrey Andrade, DDS
Dr. Carly Barrett, DDS

Patient Information

Date: _____ Social Security #: _____

Patient Name _____ Marital Status _____ Sex _____ Date of Birth _____

Address _____
Street City Zip

Email: _____ Cell: _____ Home: _____ Work: _____

Emergency Contact: _____
Name Phone # Relationship

Patient Employer/School: _____ Employer/School Address: _____

Referred By: _____ **Reason for Visit**: _____

How can we help improve your smile and oral health? _____

Billing / Insurance Information

Who is responsible for this account? _____ Relationship to Patient? _____

Primary: Insurance Company: _____ Name of Insured: _____ SSN: _____

Secondary: Insurance Company: _____ Name of Insured: _____ SSN: _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Andrade
Name of Insurance Company(ies)
Dental Family / Dr. Audrey L Andrade all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits and determine insurance benefits or the benefits payable for related services. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____ _____ _____
Signature of Responsible Party | Printed Name of Responsible Party | Date | Relationship to Patient

Minor/Child Consent

I, being the parent or guardian of _____, do hereby request and authorize the dental staff to perform necessary dental
Name of Minor/Child
services for my child, including but not limited to X-rays and administration of anesthetics that are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_____ _____ _____ _____
Signature of Responsible Party | Printed Name of Responsible Party | Date | Relationship to Patient

Financial Agreement

Payment for services rendered is due at the time services are rendered unless payment arrangements have been approved by our staff. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. Charges will also be made for broken appointments cancelled without 24 hours advance notice.

Please be aware that you are ultimately responsible for any and all charges incurred in our office.

_____ _____ _____ _____
Signature of Responsible Party | Printed Name of Responsible Party | Date | Relationship to Patient

Please Read and Initial:

_____ I authorize the staff to perform any necessary services needed during diagnosis and treatment.

_____ I grant permission and consent to Andrade Dental Family for the use of photograph(s) for presentation under any legal condition, including but not limited to: publicity, copyright purposes, illustration, advertising, and web content.

---------- ***Please Turn Over and Complete*** ---------->**

Dental / Health History

Former Dentist: _____ City/State: _____ Date of Last Dental Visit: _____

Please mark "Yes" or "No" if you experience (currently or in the past):

	Yes	No		Yes	No
Bad breath	❒	❒	Lip or cheek biting	❒	❒
Bleeding gums	❒	❒	Loose teeth or broken fillings	❒	❒
Blisters on lips or mouth / Cold sores	❒	❒	Mouth breathing	❒	❒
Burning sensation on tongue	❒	❒	Orthodontic treatment	❒	❒
Chewing on one side of the mouth	❒	❒	Pain around ear or face	❒	❒
Cigarette, cigar, or pipe smoking	❒	❒	Periodontal treatment/Deep Cleaning/Surgery	❒	❒
Clicking or popping jaw	❒	❒	Sensitivity to cold or heat	❒	❒
Dental fear or phobia	❒	❒	Sensitivity to sweets	❒	❒
Dry mouth or throat	❒	❒	Sensitivity when biting	❒	❒
Fingernail biting	❒	❒	Soda drinking	❒	❒
Food collecting between teeth	❒	❒	Sores or growths in your mouth	❒	❒
Grinding teeth / Clenching	❒	❒	Snoring or apnea when sleeping	❒	❒
Gums swollen or tender / Gum disease	❒	❒	Vape or marijuana use	❒	❒
Jaw pain or tiredness / TMJ	❒	❒			

How often do you brush? _____ How often do you floss? _____

Physician's Name: _____ City/State: _____ Date of Last Visit: _____

Please mark "Yes" or "No" if you experience (currently or in the past):

	Yes	No		Yes	No		Yes	No
Acid Reflux / GERD	❒	❒	Depression / Anxiety	❒	❒	Neurological Problems	❒	❒
ADD / ADHD	❒	❒	Diabetes	❒	❒	**Pacemaker / Defibrillator**	❒	❒
AIDS / HIV	❒	❒	Do you wear contact lenses?	❒	❒	Psychiatric Care	❒	❒
Allergies (Nasal)	❒	❒	Emphysema	❒	❒	Respiratory Disease	❒	❒
Anemia	❒	❒	Epilepsy / Seizures	❒	❒	Rheumatic/Scarlet Fever	❒	❒
Arthritis / Rheumatism	❒	❒	Fainting or Dizziness	❒	❒	Shortness of Breath	❒	❒
Artificial Heart Valves	❒	❒	Fibromyalgia	❒	❒	Sinus Infection / Hay Fever	❒	❒
Artificial Joints	❒	❒	Glaucoma	❒	❒	Sinus/Nasal Surgery	❒	❒
Asthma	❒	❒	Headaches / Migraines	❒	❒	Skin Rash	❒	❒
Back Problems	❒	❒	Heart Murmur	❒	❒	Special Diet	❒	❒
Bleeding abnormally or bruising			**Heart Problems**	❒	❒	Stroke	❒	❒
(with extractions/surgery)	❒	❒	Hepatitis (Type _____)	❒	❒	Swollen Feet or Ankles	❒	❒
Blood Disease / Disorder	❒	❒	Herpes	❒	❒	Swollen Neck Glands	❒	❒
Cancer	❒	❒	High Blood Pressure	❒	❒	Thyroid Problems	❒	❒
Drug/Alcohol Habit	❒	❒	Irritable Bowel Syndrome	❒	❒	Tonsil/Adenoid Surgery	❒	❒
Chemotherapy	❒	❒	Jaundice	❒	❒	Tonsillitis	❒	❒
Chronic Fatigue	❒	❒	Jaw Pain	❒	❒	Tuberculosis	❒	❒
Circulatory Problems	❒	❒	Kidney Disease	❒	❒	Tumor / Growth (head/neck)	❒	❒
Congenital Heart Lesions	❒	❒	Liver Disease	❒	❒	Ulcer	❒	❒
Cortisone Treatments	❒	❒	Low Blood Pressure	❒	❒	Venereal Disease	❒	❒
Cough (persistent/bloody)	❒	❒	**Mitral Valve Prolapse**	❒	❒	Weight Loss (unexplained)	❒	❒
Sleeping:								
Do you use a CPAP?	❒	❒	Do you wear a night guard?	❒	❒	Do you wear a retainer?	❒	❒
Women:						*other night appliance?* _____		
Pregnant?	❒	❒	Nursing?	❒	❒	Taking Birth Control?	❒	❒
(Due:_____)								

Allergies

❒ Aspirin ❒ Barbiturates (Sleeping Pills) ❒ Codeine ❒ Iodine ❒ **Latex** ❒ **Local Anesthetic** ❒ **Penicillin** ❒ Sulfa ❒ Other _____

Medications (list medications and reasons for taking them): _____

_____

_____

Have you ever used a **bisphosphonate medication** (common names include Fosamax, Actonel, Atelvia, Didronel, Boniva)? ❒ Yes ❒ No

If yes, when? _____ *why?*_____ *for how long?* _____ *taken:* ❒*orally* ❒*IV*

Have you ever used a **"fen-phen" drug** (Ionimin, Adipex, Fastin (phentermine), Pondimin (fenfluramine), Redux (dexfenfluramine))? ❒ Yes ❒ No

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