10017 Dixie Highway
Louisville, KY 40272
P-502.933.7250 F-502.933.7251
www.fostersmiles.com

Thank you for visiting our office! We want your visit to be pleasant and comfortable.
Please help us by completing this form *entirely*.

PATIENT INFORMATION

E-mail: ______________________________

Name ____
LAST FIRST MIDDLE INITIAL NICKNAME

Address ____
STREET

____
CITY STATE ZIP

Employer ______________________

Birth date ______________________ Height ____________ Weight ____________

Phone: Home ( ) ______________________ Social Security # ______________________

Work ( ) ______________________ Cell ( ) ______________________

Preferred method of contact ______________________

Emergency: Name ______________________ Phone ( ) ______________________

INSURANCE

Primary Dental Carrier

Subscriber Name ______________________ Social Security # ____________ DOB ____________

Employer ______________________ Insurance Co. ______________________

Insurance Co. Phone # ______________________ Group # ______________________

Relation to patient ______________________

Secondary Dental Carrier

Subscriber Name ______________________ Social Security # ____________ DOB ____________

Employer ______________________ Insurance Co. ______________________

Insurance Co. Phone # ______________________ Group # ______________________

Relation to patient ______________________

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to Foster & Foster Family Dental of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Foster & Foster Family Dental to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. This information is correct to the best of my knowledge.

Signature ______________________________ **Date** ______________

PATIENTS UNDER 18 YEARS OLD

Responsible Party ______________________ Relation to Patient ______________________

Address ____
STREET

____
CITY STATE ZIP

Telephone ( ) ______________________

---CONT'D---

OTHER INFORMATION

How did you hear about us? ______________________________

What was the reason for today's visit? ______________________________

Do you *love* your smile? ______________________________

If you don't-how would you like to change it? ______________________________

Why did you leave your last dentist? ______________________________

What did you like *most* about your last dentist? ______________________________

MEDICAL HISTORY

Conditions

- ❑ Abnormal Bleeding
- ❑ Alcohol Abuse
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Heart Valve
- ❑ Asthma
- ❑ Blood Transfusion
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Chest pain
- ❑ Colitis
- ❑ Congenital Heart Defect
- ❑ Diabetes
- ❑ Difficulty Breathing
- ❑ Drug Abuse
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Facial Surgery
- ❑ Fainting Spells
- ❑ Fever Blisters
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ HIV/Aids
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Heart Surgery
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ High Blood Pressure
- ❑ Joint Replacement
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Pace Maker
- ❑ Psychiatric Problems
- ❑ Radiation Therapy
- ❑ Rheumatic Fever
- ❑ Seasonal Allergies
- ❑ Seizures
- ❑ STD
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Ulcers

Allergies

- ❑ Aspirin
- ❑ Codeine
- ❑ Dental Anesthetics
- ❑ Erythromycin
- ❑ Latex
- ❑ Penicillin
- ❑ Sulfa
- ❑ Tetracycline

Other

____

____

Y N

❑ ❑ Do you smoke or use tobacco?

If Female

Y N

❑ ❑ Are you on birth control?

❑ ❑ Pregnant? Number of weeks____

❑ ❑ Are you nursing?

Please list any current or prior use of medication for the treatment of osteoporosis. ______________________________

Please list medications: ______________________________

____

____

TREATMENT AUTHORIZATION

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medications as indicated. I certify the above medical information is accurate to the best of my knowledge.

Payment for all treatment and services rendered are my responsibility.

______________________________ ______________________________

PATIENTS SIGNATURE DATE

If patient is a child or requires a guardian:

______________________________ ______________________________

PARENT/GUARDIAN SIGNATURE DATE