Champlain Smiles

Athena Graves, DDS

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Plattsburgh, NY 12901
(518) 324-2273

Medical Alert For Office Use

Thank you for visiting Champlain Smiles. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name _____
LAST FIRST MIDDLE INITIAL NICKNAME

Address _____
STREET

_____
CITY STATE ZIP

Employer _____ Drivers License _____

Birth date _____ Height _____ Weight _____

Phone: Home (____) _____ Social Security # _____

Work (____) _____ May we contact you at work? ❑ Yes ❑ No

Mobile (____) _____ ❑ Male ❑ Female

E-mail _____

Emergency: Name _____ Phone (____) _____

Insurance

Primary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ ID#_____Group #_____

Relation to patient _____

Secondary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ ID #_____Group#_____

Relation to patient _____

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to Champlain Smiles; Inc. of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize Champlain Smiles, Inc. to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature_____ **Date** _____

If Patient is Under 18

Responsible Party _____ Relation to Patient _____

Address _____
STREET

_____
CITY STATE ZIP

Telephone (____) _____

Other Information

How did you hear about us? (Website) (Social Media) (Facebook) (Phone book) (Work) (Flyer in Mail) (Newspaper Sticker) (Friend/Family) *(Other)*_____

What is the reason for today's visit? _____

Why did you leave your last dentist? _____

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

Medical History and Information

Conditions

- ❑ Abnormal Bleeding
- ❑ Alcohol Abuse
- ❑ Allergies
- ❑ Anemia
- ❑ Angina Pectoris
- ❑ Arthritis
- ❑ Artificial Heart Valve
- ❑ Asthma
- ❑ Bisphosphonates
- ❑ Blood Transfusion
- ❑ Cancer
- ❑ Chemotherapy
- ❑ 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
- ❑ HPV
- ❑ Joint Replacement
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Pace Maker
- ❑ Psychiatric Problems
- ❑ Radiation Therapy
- ❑ Rheumatic Fever
- ❑ Seizures
- ❑ Sexually Transmitted Disease
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Ulcers

Allergies

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

Other _____

_____

Y	N	
❑	❑	Do you Smoke or use Tobacco?

If Female

Y	N	
❑	❑	Are you taking Birth Control Pills?
❑	❑	Are you pregnant? If yes, # of weeks_____
❑	❑	Are you nursing?

Other Conditions**:** _____

Please list any medications you are currently taking: _____

_____

Primary Doctor: _____ Phone #: _____

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between Champlain Smiles, Inc. and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

_____ _____

PATIENT'S SIGNATURE DATE

If patient is a child or requires a guardian:

_____ _____

PARENT/GUARDIAN SIGNATURE DATE