Aeris Family Dental

Dr. Lanoy Alston, D.M.D., Dr. Lan Allen, D.M.D., Dr. Kevin Mortenson, D.M.D., Dr. Cameron Hulse, D.D.S.

Name_____ Preferred Name_____
Patient DOB_____ Patient SS#_____
Home#_____ Cell #_____ Work#_____
Home Address _____
City _____ State _____ Zip Code _____
Email Address _____
Occupation_____Employer_____
Emergency Contact_____#_____ Relationship_____
Whom may we thank for your referral? _____

Primary Insurance

Name of Insurance Carrier_____ Subscriber's Name_____
Subscriber ID or SS#_____ Subscriber DOB_____
Employer_____ Relationship to Subscriber_____
Secondary Insurance □ Yes □ N

□ Anemia/Hemophilia	□ Heart Surgery	□ Radiation
□ Asthma	□ Artificial Valves	□ Glaucoma
□ Respiratory Disease	□ Artificial Joints	□ Rheumatic Fever
□ Difficulty Breathing	□ Arthritis	□ Ulcers/Colitis
□ Emphysema	□ Epilepsy/Seizures	□ Fever Blisters/Herpes
□ Tuberculosis	□ Fainting Spells	□ Hepatitis A / B / C
□ Blood Pressure □H □L	□ Neurological Problems	□ HIV/Aids
□ Angina	□ Thyroid Problems	□ STD
□ Congenital Heart Defect	□ Diabetes	□ Drug/Alcohol Abuse
□ Heart Attack/Stroke	□ Cancer	□ Neck/Shoulder Pain
□ Heart Murmur/MVP	□ Chemotherapy	□ Frequent Headache

Other Please Specify_____
Do you smoke or chew tobacco? □Y □N How often? _____
Are you taking oral contraceptives? □Y □N
Are you pregnant? □Y □N Due Date:_____
Are you nursing? □Y □N
Have you been hospitalized in the last 5 years (other than pregnancy related)?_____
When:_____ Reason:_____
When:_____ Reason:_____
Are you taking any prescription drugs or herbal medications? (Please List)_____
_____
_____
Are you allergic or had any adverse reaction to any of the following?

□Metals	□Antibiotics_____
□Latex	□Pain Medication_____
□Anesthetics	□Other_____

Have you been told you need to premedicate before dental treatment? _____

The above information is true and correct to the best of my knowledge. I understand that this information will be held in strict confidence, and that it is my responsibility to inform this office of any changes in my medical history. I authorize my insurance benefits to be paid directly to Aeris Family Dental. **I understand that I am financially responsible for any balance**. I also authorize Aeris Family Dental to release any information necessary to process my insurance claims.

Signature of Patient or Parent/Guardian Date

Acknowledgment of Receipt of Privacy Practices

I acknowledge that I have read and understand our Notice of Privacy Practices from Aeris Family Dental

Signature of Patient or Parent/Guardian Date