Blue Sky Dental Care

2120 Blue Spruce Dr. E #B
Bel Air, MD. 21015
410 569-9492

Medical Alert For Office Use

Thank you for visiting Blue Sky Dental Care. We want your visit to be pleasant and comfortable. Please help us by completing this form.

How did you hear about us? _____

Name _____ (LAST / FIRST / MIDDLE INITIAL / NICKNAME)

Address _____ (STREET)

_____ (CITY / STATE / ZIP)

Employer _____ Driver's License _____

Birth date _____ _____ _____

Email: _____

Phone: Mobile (___) _____ Social Security # _____

Work (___) _____ May we contact you at work? ☐ Yes ☐ No

Home (___) _____ ☐ Male ☐ Female

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 (United Concordia, Cigna PPO, MetLife, Delta Premiere, Delta Dental)

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 the Dental Office of the group insurance benefits otherwise payable to me. I understand that I a responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform su diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical histo 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 (___) _____

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
- ☐ 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
- ☐ 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?

Please list any medications you are currently taking: _____

_____

HAVE YOU EVER TAKEN BISPHOSPHONATE, CLODRONATE, PAMIDRONATE OR ZOLEDRONIC ACID

Treatment Authorization Form

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

Payment for all treatment and services rendered are my responsibility.

_____ _____

PATIENTS SIGNATURE SIGN AND PRINT DATE

If patient is a child or requires a guardian:

_____ _____

PARENT/GUARDIAN SIGNATURE SIGN AND PRINT DATE