Normandy Dental
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We are happy to have you here at Normandy Dental and want your appointment to go as smoothly as possible. Our office policy is to receive payment by cash, credit card or check at the time services are rendered. Please feel free to ask any questions regarding your treatment, appointments or fees.

Patient Information

Name_____DOB_____ Sex (circle one) M F

Address_____City_____State_____Zip_____

Home ph_____ Cell ph_____Wk Ph_____

Employer_____Occupation_____

Insurance Co._____Policy/ID#_____

E-mail_____

SS#_____Marital Status_____

Spouse Information

Name_____DOB_____ Sex (circle one) M F

Address_____City_____State_____Zip_____

Home ph_____ Cell ph_____Wk Ph_____

Employer_____Occupation_____

Insurance Co._____Policy/ID#_____

E-mail_____

SS#_____Marital Status_____

Account will be paid today by cash___credit card___check___Dr. will quote fees and payment is required at that time. No temporary checks accepted. You must have a current TDL and work phone number available.

How did you hear about our office?_____

Purpose of visit_____

(ADULT FORM)

HEALTH HISTORY

Have you ever been treated for or diagnosed for any of the following? Indicate by answering yes or no.

YES or NO	Heart Trouble	YES or NO	Heart Murmur
YES or NO	Rheumatic Fever	YES or NO	Valve Replacement
YES or NO	Asthma	YES or NO	Mitral Valve Prolapse
YES or NO	Kidney Problems	YES or NO	Arterial Grafts
YES or NO	High Blood Pressure	YES or NO	Organ Transplants
YES or NO	Epilepsy	YES or NO	Diabetes
YES or NO	Hepatitis	YES or NO	Joint Replacement
YES or NO	Implants	YES or NO	Tuberculosis
YES or NO	HIV Positive	YES or NO	Shunts (head/body)
YES or NO	AIDS	YES or NO	Other (list below)

_____

Other_____

Do your gums bleed?_____ Do you have a bad taste in your mouth or mouth odor?_____

Have you experienced any ill effect s or allergic reaction from Novocain, Penicillin, or any other drug?_____

If yes, please list._____

List any medications you are taking (prescribed or not)

_____

_____

Have you experienced any unfavorable reactions from previous dental work?

_____

Name of medical doctor_____Phone_____

I understand the need for, and consent to, the use of local anesthesia when necessary for dental procedures. I understand the risks, although unlikely, including but not limited to partial or total numbness and allergic reactions.

Signature_____Date_____

I HEREBY ASSIGN ALL DENTAL AND MEDICAL BENEFITS TO WHICH I AM ENTITLED TO NORMANDY DENTAL . A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED VALID AS AN ORIGINAL. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT.

Signature_____Date_____