Sikka Dental Corporation General Paperwork

Patient Information

Full Name:____

First Name Middle Name Last Name

Sex: Male / Female Date of Birth: MO / DAY / YEAR AGE:_________ Social Security Number:_FULL NUMBER REQUIRED_

Marital Status: Single / Married / Separated / Divorced / Widowed Is patient a Minor? Yes / NO

Minors Primary Residence? Both Parents / Mother / Father / Stepparent / Guardian / OTHER:______________________

Patients Occupation:____ or Minors School:______________________________

Email Address:____@__________________________________.com

1. Main Phone Number: ( ) Type: Work / Cell / Home / Other:____________________
2. Alternate Phone Number: ( ) Type: Work / Cell / Home / Other:____________________

I understand that providing this information, is a consent for communication with Sikka Dental Corporation about any and all matters of my care and accounts. If I choose to decline email or text communication at a later time, Sikka Dental Corporation will accept an Optout request anytime received in writing.

Home Address:____

House Number Street Name Unit # City Zip Code

Emergency Contact:____

Name Phone Number Relationship

☐ **YES, I have read and understand the following Disclaimer Statement:** As a courtesy to our patients, Sikka Dental Corporation will help file insurance claim forms to your insurance carrier in an effort to collect account balances. Sikka Dental Corporation cannot guarantee or warrant any insurance payments, claim payments are paid based upon your groups plan provisions and limitations that are selected by your employer. Plan changes are subject to change without notice to Sikka Dental and unforeseen circumstances are a possibility. Any lack of payment from your insurance carrier will result in monies due to Sikka Dental Corporation and will need to be paid under the office policies and procedures in a timely manner.____________ (initials)

MEDICAL HISTORY

Are you currently a patient of record with your Medical Doctor? ☐ YES ☐ NO When was your last visit? MONTH/YEAR

Your Medical Physicians Full Name:____ Office Phone #: ( )

Group or Practice Name:____ City:___________________________________

Have you been Hospitalized in the last 2 years? ☐ YES ☐ NO

If YES, what for?____

If YES, are you taking any medications, drugs, or pills (Please list below IN SECTION 6)? ☐ YES ☐ NO

WOMAN ONLY:

Are you Pregnant? ☐ YES, How far along?__________ ☐ NO Are you Nursing? ☐ YES ☐ NO

Are you taking Birth Control Pills? ☐ YES ☐ NO Are you on Hormone Therapy? ☐ YES ☐ NO

CIRCLE YES OR NO FOR ANY OF THE FOLOWING IF YOU PRESENTLY HAVE OR HAVE HAD IN THE CONDITION IN THE PAST:

1. ALLERGIES

Yes / No Aspirin
Yes / No Penicillin or other antibiotics
Yes / No Nitrous oxide
Yes / No Valium or other sedatives
Yes / No Latex
Yes / No Local anesthetic
Yes / No Codeine or other narcotics
Yes / No Food
Yes / No Metal

OTHER:____

2. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING?

Yes / No Chest Pain
Yes / No Fainting spells
Yes / No Recent significant weight loss
Yes / No Fever
Yes / No Night Sweats
Yes / No Persistent cough
Yes / No Coughing up blood
Yes / No Bleeding problems
Yes / No Blood in urine
Yes / No Blood in stools
Yes / No Diarrhea or constipation
Yes / No Frequent urination
Yes / No Difficulty urinating
Yes / No Ringing in ears
Yes / No Headaches
Yes / No Dizziness
Yes / No Blurred vision
Yes / No Bruise easily
Yes / No Frequent vomiting
Yes / No Jaundice
Yes / No Dry Mouth
Yes / No Excessive thirst
Yes / No Difficulty swallowing
Yes / No Swollen ankles
Yes / No Joint pain or stiffness
Yes / No Shortness of breath
Yes / No Sinus problems

OTHER:____

Sikka Dental Corporation General Paperwork

3. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING?

Yes / No Heart disease
Yes / No Family history of heart disease
Yes / No Heart attack
Yes / No Artificial joint
Yes / No Stomach problems or ulcers
Yes / No Heart defects
Yes / No Heart murmurs
Yes / No Rheumatic fever
Yes / No Skin disease
Yes / No Hardening or arteries
Yes / No High blood pressure
Yes / No Seizures
Yes / No Cosmetic surgery

Yes / No AIDS/HIV
Yes / No Surgeries
Yes / No Hospitalization
Yes / No Diabetes
Yes / No Family history of diabetes
Yes / No Tumors or cancer
Yes / No Chemotherapy
Yes / No Radiation
Yes / No Arthritis, rheumatism
Yes / No Emphysema/ other lung disease
Yes / No Kidney or bladder disease
Yes / No Stroke
Yes / No Eating disorders

Yes / No Psychiatric care
Yes / No Osteoporosis
Yes / No Thyroid disease
Yes / No Asthma
Yes / No Hepatitis
Yes / No Sexual transmitted disease
Yes / No Herpes
Yes / No Canker or cold sores
Yes / No Anemia
Yes / No Liver disease
Yes / No Eye disease
Yes / No Transplants
Yes / No Tuberculosis

OTHER:____

4. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING?

Yes / No Recreational drugs
Yes / No Over-the-counter medicines
Yes / No Weight loss medications
Yes / No Anti-Depressants

Yes / No Tobacco in any form
Yes / No Alcohol
Yes / No Bisphosphonate (Fosamax)
Yes / No Herbal Supplements

Yes / No Antibiotics
Yes / No Supplements
Yes / No Aspirin

Please list all prescription medications BELOW in SECTION 6.

5. ALL PATIENTS

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain:____

____

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why:______________________

Yes / No Have you ever taken Fen-Phen? If YES, when:______________________

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in PRIVATE?**

6. MEDICATION LIST

DRUG NAME	CONDITION THE DRUG IS TREATING	DOSAGE/FREQUENCY

7. If there is any additional conditions or information that you have not already listed above please use this space provided:

I certify that I have read and understand all 3 pages of the General Paperwork forms. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of the team, responsible for any errors or omissions that I may have made in the complete of this form.

______________________ ____________ ______________________ ____________

Signature of Patient (Parent or Guardian) **Date** **Signature of Dentist** **Date**