WILLIAM W. DREYER, DMD, PA
44 PORTLAND ST. SUITE 1
FRYEBURG, ME 04037

Name ______________________ Prefer to be Called ______________________

Address ____
Street City State Zip Code

Employer ______________________ Occupation ______________________
Home Telephone ____________ Bus Telephone ____________ Soc. Sec. # ____________
Birth Date ____________ Sex ______ Marital Status: S___ M ___W ___D ___Email ____________
Who may we thank for referring you? ______________________
Or, how did you hear about our office? ______________________
Person to contact in case of emergency ______________________

Person Responsible for Payment of Account

Name ______________________ Relationship to Patient ______________________
Address ____
Street City State Zip Code
Employer ______________________ Occupation ______________________
Business Address ____
Street City State Zip Code
Home Telephone ______________________ Business Telephone ______________________
Birth Date ____________ Sex _____ Soc. Sec.# ____________ Email ____________

Dental Insurance Information

Primary Insurance Co. ______________________ Employer ____________
Subscriber's Name ______________________ Soc. Sec. # ____________
Group Number ____________ Patient's Relationship to Subscriber: Self _____ Spouse ______ Child _____
If patient is a Student, Name of School ______________________

Secondary Insurance Co. ______________________ Employer ____________
Subscriber's Name ______________________ Soc. Sec. # ____________
Group Number ____________ Patient's Relationship to Subscriber: Self ______ Spouse ______ Child _____

I authorize the release of any information necessary to process my insurance claim.

Signed ____ Date ____________

I hereby authorize payment to the dentist of the insurance benefits otherwise available to me.
A copy of this signature is as valid as the original.

Signed ____ Date ____________

1. Have you been under the care of a medical doctor during the past two years? .... Yes No
If yes, for what? ____

Physician's Name ______________________________ Phone ________________
Address ____
City State Zip

2. Have you taken any medication or drugs during the past two years? .... Yes No
3. Are you taking any medication, drugs or pills now, including regular dosages of aspirin? .... Yes No
If yes, please list ____

4. Have you ever taken prescription medications for weight loss (diet pills)? Yes No
If yes, did you take any of the following: Yes No Fen-Phen (Fenfluramine-Phentermine)
Yes No Pondimen (Fenfluramine)
Yes No Redux (Desfenfluraming)
If yes to any of the above, did you have a medical exam for potential heart problems? .... Yes No

5. Have you been a patient in the hospital during the past five years?.. Yes No
6. Are you aware of having an allergic (or adverse) reaction to any medication or substance? .... Yes No
If yes, please list ____
7. Do you use more than two pillows to sleep? .... Yes No
8. Have you lost or gained more than 10 pounds in the past year? .... Yes No
9. **Women:** Are you: Pregnant? _____ Months _____ Nursing? _____ Taking birth control pills? ______

Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)...	Yes	No	Ulcers	Yes	No	Hepatitis A B C (circle)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	H.I.V. Positive	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	Arthritis/Rheumatism	Yes	No
High Blood Pressure	Yes	No	Glaucoma	Yes	No	Headaches	Yes	No
Heart Murmur	Yes	No	Contact Lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema.	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve...............	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Stint or Shunt	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Aneurism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Rheumatic Fever	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)............	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (Hip, Knee, etc) ...	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble.	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care ..	Yes	No

10. Do you have or have you had any disease, condition, or problem not listed? .... Yes No
If yes, please list: ____

11. **Do any of the above conditions require you to premedicate with antibiotic before a dental procedure is performed? .... Yes No**

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication.

Patient/Guardian Signature ______________________________ Date ________________

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) ________________________________’s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives, fluoride, and other medication as necessary. I understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor’s or designated staff’s use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless prior arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 ½% late charge (18%APR) may be added to my account. If required, I also understand a check of my credit history may be made.

6. Any fees incurred in an effort to enforce payment required of this agreement will be paid by the patient.

7. There will be a $25.00 handling charge for any returned check.

Patient Signature ____________________________ Date ___________ Witness __________________

Parent/Responsible Party’s Signature ____

Relationship to Patient ____