WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

LEGACY DENTAL
Mark Friedrich DDS, Nathan Bojrab DDS, Margaret Neese DDS • 7215 Engle Road, Fort Wayne, IN 46804 • 260-434-1133

1 ABOUT YOU

Today's Date: ______________________

Name: ______________________
Last First MI Mr. Mrs. Ms. Dr.

I prefer to be called: ______________ ❒ Male ❒ Female

Birthdate: ______________ Age: ________

SS#: ______________ DL#: ______________

Home Address: ______________________
Apt/Condo #

____
City State Zip

❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated

Hm #: ______________________

Cell #: ______________________

Hm E-mail: ______________________

Wk E-mail: ______________________

Wk #: ______________ Ext. ________

Employer: ______________________

Employer's Address: ______________________

How long there? ________ Occupation: ______________

Where & when are best times to reach you? ______________

____

2 SPOUSE INFORMATION

His/Her Name: ______________________

Employer: ______________________

Wk #: ____________ Ext. ________ SS #: ____________

Birthdate: ______________________

Hm #: ______________________

Cell #: ______________________

Home Email: ______________________

3 WHOM MAY WE THANK?

Please check a referral source below.

❒ Google

❒ Social Media (Facebook, Twitter, Instagram) Please List:

____

❒ Website

❒ TV/Radio, Newspaper, Magazine (Please List)

____

❒ Community Event/Fair ______________________

❒ Family/Friend ______________________

❒ Other ______________________

4 DENTAL INSURANCE

Insurance Co. Name: ______________________

Insurance Co. Address: ______________________

Insurance Co. Phone #: ______________________

Group # (Plan, Local or Policy #): ______________

Insured's Name: ______________ Relation: ____________

Insured's Birthdate: ____________ Insured's SS #: ____________

Insured's Employer: ______________________

Insured's Address: ______________________

Secondary Dental Insurance

Insurance Co. Name: ______________________

Insurance Co. Address: ______________________

Insurance Co. Phone #: ______________________

Group # (Plan, Local or Policy #): ______________

Insured's Name: ______________ Relation: ____________

Insured's Birthdate: ____________ Insured's SS #: ____________

Insured's Employer: ______________________

Insured's Address: ______________________

In the event of an emergency, is there someone who lives near you that we should contact?

His/Her Name: ______________ Relation: ____________

Wk #: ______________ Hm #: ____________

Address: ______________________

____

CONTINUED ON BACK

What is the reason for today's visit? ____________________

Do you have any questions or concerns we can help you with today? ____________________

Do you love your smile? ____________________

Is there anything you would like to change? ____________________

What did you like most about your last dentist? ____________________

What did you like least about your last dentist? ____________________

Have you ever had botox or dermal fillers? ____________________

5 MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: ____________________

Phone #: ____________________ Date of last visit: ____________

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: ____________________

Are you taking any prescription/over the counter drugs? ❑ Yes ❑ No

Please list each one: ____________________

For Women:

Are you pregnant? ❑ Yes ❑ No Due Date: ____________

Please list any serious medical condition(s) that you have ever had: ____________________

Are you allergic to any of the following?

❑ Aspirin ❑ Erythromycin ❑ Tetracycline
❑ Codeine ❑ Latex ❑ Other
❑ Novocaine ❑ Penicillin

Please list any other drugs that you are allergic to: ____________________

MEDICAL HISTORY CONTINUED

Have you ever had any of the following diseases or medical problems?

- ❑ Abnormal Bleeding
- ❑ Alcohol Abuse
- ❑ Allergies
- ❑ Anemia
- ❑ Angina Pectoris
- ❑ Arthritis
- ❑ Artificial Bones
- ❑ Artificial Heart Valve
- ❑ Asthma
- ❑ Blood Transfusion
- ❑ Cancer/Chemotherapy
- ❑ Colitis
- ❑ Congenital Heart Defects
- ❑ Cosmetic Surgery
- ❑ Diabetes
- ❑ Difficulty Breathing
- ❑ Drug Abuse
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fainting Spells
- ❑ Fever Blisters
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ Hay Fever
- ❑ Heart Attack
- ❑ Heart Surgery
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ High Blood Pressure
- ❑ HIV + (AIDS)
- ❑ Jaundice
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Pneumocystosis
- ❑ Psychiatric Problems
- ❑ Radiation Therapy
- ❑ Rheumatic Fever
- ❑ Seizures
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Venereal Disease

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

I understand that I am responsible for payment of services rendered and shall be responsible for any court costs and attorney fees if they are deemed ncessary for collection of debt. I further consent to jurisdiction for any litigation being granted in Allen County, Indiana.

____________________ ____________________
Signature Date

Payment is due in full at the time of treatment.

We want our patients to be able to comfortably afford dental care.
We will gladly discuss our financial policies with you before beginning your treatment.
We require 48 hours notice to change or cancel an appointment to avoid being charged for the appointment.

Thank you for filling out this form completely. It will enable us to help you more effectively.
If you have any questions at any time, please ask us. We are happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.