MAGIC DENTAL CARE
6050 BABCOCK ST., S.E., SUITE NO. 2 • PALM BAY, FL 32909 • (321) 725-9946

PATIENT INFORMATION

Name _____ Sex ❑ Male ❑ Female Age _____

Birthdate _____ Social Security # _____

Address _____

City _____ State _____ Zip Code _____

Home Phone_____ Cell Phone _____ Work Phone _____

Whom may we thank for referring you? _____

Name of Insured _____ Relation to patient _____

Birthdate _____ Social Security # _____

Whom may we notify in case of emergency? _____

Home Phone_____ Cell Phone _____ Work Phone _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Women: Are you pregnant? ❑ Yes ❑ No ~ Nursing? ❑ Yes ❑ No ~ Taking birth control pills? ❑ Yes ❑ No

Please check (✔) if you have or have had any of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
❑	❑	AIDS	❑	❑	Diabetes	❑	❑	Jaw Pain	❑	❑	Shortness of Breath
❑	❑	Anemia	❑	❑	Epilepsy	❑	❑	Kidney Disease	❑	❑	Skin Rash
❑	❑	Arthritis, Rheumatism	❑	❑	Fainting	❑	❑	Liver Disease	❑	❑	Stomach Problems
❑	❑	Artificial Heart Valves	❑	❑	Glaucoma	❑	❑	Mitral Valve Prolapse	❑	❑	Stroke
❑	❑	Artificial Joints	❑	❑	Headaches	❑	❑	Nervous Problems	❑	❑	Swelling of Feet or Ankles
❑	❑	Asthma	❑	❑	Heart Murmur	❑	❑	Pacemaker	❑	❑	Thyroid Problems
❑	❑	Blood Disease	❑	❑	Heart Problems	❑	❑	Radiation Treatment	❑	❑	Tobacco Habit
❑	❑	Cancer			Describe _____	❑	❑	Do your gums bleed	❑	❑	Tonsillitis
❑	❑	Chemotherapy	❑	❑	Hemophilia			when you brush?	❑	❑	Tuberculosis
❑	❑	Circulatory Problems	❑	❑	Hepatitis	❑	❑	Respiratory Disease	❑	❑	Ulcer
❑	❑	Cortisone Treatment	❑	❑	High Blood Pressure	❑	❑	Rheumatic Fever	❑	❑	Venereal Disease
❑	❑	Cough, Persistent	❑	❑	HIV Positive	❑	❑	Scarlet Fever			

Please list any medications you are currently taking: _____

Please list any allergies: _____

PERMIT FOR OPERATIONS: This is to certify that I, undersigned, consent to the performing of the dental and oral surgery procedure agreed to be necessary or advisable, including the use of local or general anesthesia as indicated.

AUTHORIZATION: I have reviewed this questionnaire and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment, and I agree to notify the dentist if any change in my health status should occur.

I AUTHORIZE the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize use of this signature on all insurance claim submissions.

I UNDERSTAND that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

Patient's
(Parent's)
Signature X_____ **Date** _____