phoenix dental

"Rise And Smile"

FAMILY DENTAL CLINICS

Dr.Dylan Nicholas Partap (D.D.S) Dr. Aaron Justin Partap (D.D.S)
& Associate Dental Surgeons

Phone: Toll Free 800 - DENT (3368) / PHO-ENIX (746-3649) Email:phoenixdentalclinics@gmail.com

☐ #818 S.M.R. California, Pt. Lisas. (868) 686-DENT (3368)
☐ Valpark Shopping Plaza, Valsayn.(868) 723-DENT (3368)
☐ Unit 7,Milford Bay Plaza. (868) 737-DENT (3368)
Crown Point, Tobago

☐ #765 S.M.R. Couva. (868) 636-DENT (3363)
☐ #38 Corinth Road, San Fernando (868) 499-DENT(3368)

PATIENT NAME:	HOME/ CELL NUMBER:
HOME ADDRESS:	BIRTH DATE:
PLACE OF WORK:	WORK CONTACT NUMBER:

MARITAL STATUS
☐ Single ☐ Married ☐ Common Law ☐ Widow ☐ Will Not State

NEXT OF KIN/EMERGENCY CONTACT INFORMATION:	RELATIONSHIP TO PATIENT
NAME:	HOME /CELL PHONE:
HOME ADDRESS:	BIRTH DATE:

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐ **SELF** ☐ **SPOUSE** ☐ **PARENT** ☐ **EMPLOYER** ☐ **FRIEND** ☐ **BUSINESS CARD** ☐ **RELATIVE** ☐ **SIGN AT BUILDING**

WHERE DID YOU FIND THE PHONE NUMBER TO THIS OFFICE? _____

IF YOU WERE REFERRED, WHOM MAY WE THANK FOR REFERRING YOU? _____

CONSENT FORM

I WILL ANSWER ALL HEALTH QUESTIONS TO THE BEST OF MY KNOWLEDGE _____
INITIAL

After explanation by the doctor, I hereby authorize the performance of dental service upon the above named patient and whatever procedure that the judgement of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and X-rays as may be deemed necessary and advisable by the doctor.

SIGNATURE **DATE** **SIGNATURE OF PARENT/GUARDIAN IF PATIENT IS A MINOR**

_____ _____ _____

TERMS AND CONDITIONS

The office depends on reimbursement from the patient for the cost incurred in their case. The financial responsibility of each patient must be determined before treatment as a condition of treatment by this office, I understand financial agreements must be made in advance. All emergency dental services, or for any dental service performed, prior financial arrangements must be made for at the time the services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for the payment. If I carry insurance, I understand that this office will help prepare my insurances to assist in making collections from insurance companies and will credit such collections to my account. This office is not responsible for any errors that may occur during the electronic or manual processing of insurance cards/forms.

Previous Dentist_____Date of Last Visit _____

Medical Doctor/Physician _____

How often do you brush your teeth? _____ Do you Floss? ☐ Yes ☐ No

Please tick where applicable:

☐ I clench or grind my teeth during the day/while sleeping. ☐ I have had a facial/jaw injury. ☐ I have had orthodontics.
☐ My gums bleed while brushing my teeth or flossing. ☐ I have problems eating ☐ My gums feel tender or swollen
☐ I am interested in making my smile straighter. ☐ I am interested in whitening my teeth.

Do you or have you had any of the following? Please tick where applicable

☐ Heart disease
☐ Heart murmur/Mitral Value Prolapse
☐ Stroke
☐ Congenital/ Heart Disease
☐ Rheumatic Fever
☐ Abnormal Blood Pressure
☐ Asthma
☐ Hay Fever
☐ Sinus Trouble
☐ Epilepsy /Seizures
☐ Ulcers
☐ Implants/Artificial Joints: HIP ☐ KNEE ☐ OTHER
☐ I smoke or use tobacco. How much per day? _____
How many years? _____.
☐ I have consumed alcohol within the last 24 hours
☐ I usually take antibiotics prior to dental treatment
☐ I have had major surgery.
Year: _____.Type of surgery_____
☐ Anesthesia resistance or allergy to pain killers
☐ Diabetes
☐ Excessive urination and or thirst
☐ Infection /Mononucleosis(Mono)
☐ Anemia
☐ Prolonged Bleeding Disorder
☐ Tuberculosis or lung Disease
☐ Kidney disease
☐ Tumor or Malignancy
☐ HIV/AIDS
☐ Immune Suppressed Disorder

Doctors Notes ONLY

☐ Hearing Loss
☐ Fainting Spell
☐ Glaucoma
☐ History of Emotional or Nervous Disorder
☐ Herpes
☐ Arthritis
☐ Sexually transmitted disease
☐ History of drug addiction
☐ Cancer/Chemotherapy
☐ Radiation Treatment
☐ Are you taking birth control pills or pregnant.

Please indicate any other medical issue that is not outlined above.

_____
_____
_____
_____
_____

Are you allergic to any of the following?

☐ Aspirin ☐ Codeine
☐ Penicillin ☐ local Anesthetics(Novocain)
☐ Latex ,Metals, Plastic ☐ Other medication_____
☐ Ibuprofen
☐ Sulfa Drugs/Sulfites/Sulfides

Please list all medications you are currently taking:

Medicine_____ Condition_____
Medicine_____ Condition_____
Medicine_____ Condition_____
Medicine_____ Condition_____