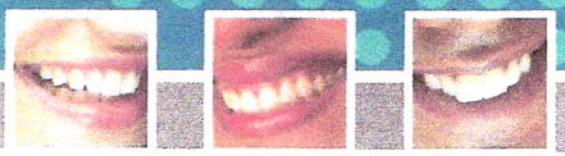
Coastal Dental Associates III, LLC
20 Clinton Ave
Jamestown, RI 02835

(401)423-2110
jamestown@coastaldentalgrp.com
jamestown@coastaldentalgrp.com



Patient Information Form

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____

_____ (City) _____ (State) _____ (Zip Code)

Would you be interested in Sedation Dentistry?

◯ Yes ◯ No

On a scale of 1-10, how nervous are you about coming to the dentist?

_____

Pharmacy Name and Phone Number

_____

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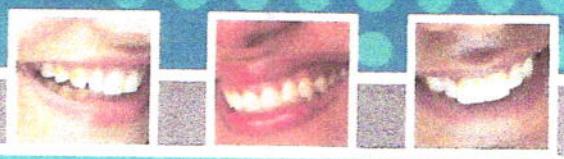

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____

_____ City _____ State _____ Zip Code

Primary Insurance

Name of Insured: _____ Last _____ First _____ MI

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____

_____ City _____ State _____ Zip Code

Insured's Employer Name: _____

Employer Address: _____

_____ City _____ State _____ Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____

_____ City _____ State _____ Zip Code

Secondary Insurance

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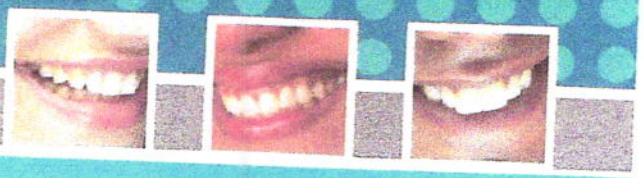

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____

_____ City _____ State _____ Zip Code

Insured's Employer Name: _____

Employer Address: _____

_____ City _____ State _____ Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____

_____ City _____ State _____ Zip Code

Response Date: _____

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Medical & Dental History Form

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health?

◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam?

_____

Within the past year, have there been any changes in your general health?

◯ Yes ◯ No

Your Primary Care Physician's name,address, & phone number

_____

Please mark any of the following to indicate YES in response to the question:

☐ Have you ever had complications following dental treatment?

☐ Are you currently under the care of a physician due to a specific condition?

☐ Have you been hospitalized within the last 2 years due to a surgery or illness?

☐ Are you currently takingany prescriptions or non-prescription medications? Please list below.

☐ Do you use tobacco (smoking or chewing)?

☐ Have you ever had a blood transfusion?

☐ Do you have any other conditions, diseases, etc., not listed that we should be aware of?

If any of the previous questions are marked please explain:

_____

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WOMEN ONLY: Are you pregnant or think you may be pregnant?

◯ Yes ◯ No

List of Medications:

Additional Notes: