Main Street Family Dentistry, P.C.
Adam Elsner, DDS
712 W. Main Street, Ste. 100
Plainfield, IN 46168 (317) 839-5500

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest dental care available. If you have any questions, please do not hesitate to ask us.

Patient Information

Date_____ Home Phone (____)_____Cell (____)_____ First

Name_____ Middle_____ Last_____ Preferred

Name_____ Birthdate _____ SS#_____

Address_____ City_____ State _____Zip_____

Check Appropriate Boxes ☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Patient's Employer _____Phone# (____)_____Occupation_____

Business Address_____ City _____State _____Zip_____ E-

mail (if patient is a minor, use parent's)_____

Spouse or Parent's Name_____Employer_____Phone(___)_____ If

Student, Name of School or College_____ City _____State_____

Emergency Contact Person _____Phone (____)_____

Whom May We Thank for Referring You?_____

Person Responsible For This Account

Name_____ Birthdate _____Relation_____

Address_____ Phone (____)_____

Driver's License # _____ SS# _____ Bank_____

Employer Address & Phone_____

Currently a Patient of Ours?_____ E-mail _____ Cell # (____)_____

Primary Insurance Company

Name of Insured_____ Birthdate _____Relation _____

SS# _____ Date Employed_____ Work Phone (___) _____

Employer Name & Address _____

Insurance Company_____ Member ID _____Group #_____

Address_____ City_____ State _____Zip_____

Secondary Insurance Company

Name of Insured_____ Birthdate_____ Relation _____

SS# _____ Date Employed_____ Work Phone (___)_____

Employer Name & Address_____

Insurance Company_____ Member ID _____ Group # _____

Address_____ City_____ State _____ Zip_____

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Patient Medical History

Physician_____ Office Phone_____ Last Exam_____

		Yes	No
1.	Are you under medical treatment now?	☐	☐
2.	Have you had any surgical operations or serious illnesses within the last five years?	☐	☐
3.	Do you use tobacco?	☐	☐
4.	Do you use controlled substances?	☐	☐
5.	Do you need to be pre-medicated before dental appointments? If so, what medication? _____	☐	☐
6.	Do you currently take any medications? Please list all medicines(including over-the-counter) _____ _____ _____	☐	☐

Are you allergic to or had any reactions to any of the following:

	Yes	No
Local Anesthetics (ex. Novocaine)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (ex. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐

For Women only:

Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

Do You Have *or* Have You Had Any Of The Following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Stroke	☐	☐
Fainting/ Seizures	☐	☐	Heart Murmur	☐	☐	Hay Fever/ Allergies	☐	☐
Asthma	☐	☐	Angina	☐	☐	Tuberculosis	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Radiation Therapy	☐	☐
Epilepsy/ Convulsions	☐	☐	Cancer	☐	☐	Glaucoma	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Recent Weight Loss	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Liver Disease	☐	☐
Kidney Disease	☐	☐	Hepatitis/ Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV	☐	☐	Sexually Transmitted Disease	☐	☐	Anxiety	☐	☐
Thyroid Problem	☐	☐	Stomach Trouble	☐	☐	Mitral Valve Prolapse	☐	☐
							☐	☐

Patient Dental History

Name of Previous Dentist and Location_____ Date of Last Exam_____

		Yes	No
1.	Do your gums bleed while brushing or flossing?	☐	☐
2.	Do you feel pain to any of your teeth?	☐	☐
3.	Have you had any head, neck or jaw injuries?	☐	☐
4.	Have you ever experienced any of the following problems in your jaw?		
	Clicking	☐	☐
	Pain (joint, ear, side of face)	☐	☐
	Difficulty in opening, closing, or chewing	☐	☐
5.	Do you have any sores or lumps in or near your mouth?	☐	☐
6.	Do you have frequent headaches?	☐	☐
7.	Do you clench or grind your teeth?	☐	☐
8.	Have you ever had prolonged bleeding following an extraction?	☐	☐
9.	Have you had braces or expanders?	☐	☐
10.	Do you wear dentures or partials?	☐	☐
11.	Do you like your smile?	☐	☐
	If no, why not? _____		

Authorization and Release

I certify that I have read and understand the above information and have answered accurately to the best of my knowledge. I understand that giving incorrect information can be dangerous to my health. I authorize this office to release my personal health records as needed to collect payments, and to communicate with other health care providers as needed for treatment. I authorize and request my insurance company to pay directly to the dentist or dental office benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand and agree to be responsible for any amount not covered by insurance. I agree to be responsible for payment of all services rendered on behalf of myself or my dependents, whether covered by insurance or not.

I authorize treatment for myself and my dependents by Main Street Family Dentistry, P.C.

X_____ Date_____

Signature of patient (parent or guardian of a minor)

_____

Name and relationship of person signing