Medical History

Patient Name:__________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY YOU WILL RECEIVE. Thank you for answering the following questions.

Date of Previous Dental Visit:___________________________

Previous Dentist's Name:_______________________________

Are you under a physician's care now? ☐Yes ☐No ☐N/A ___________

Have you ever been hospitalized or had a major operation? ☐Yes ☐No ☐N/A

Have you ever had a serious head or neck injury? ☐Yes ☐No ☐N/A_________

Do you use tobacco? ☐Yes ☐No ☐N/A__________________________________

Do you take, or have you taken Phen-Fen or Redux? ☐Yes ☐No ☐N/A

Please list any medications, pills or drugs you are taking:____________________________________

Woman: Are you Pregnant/trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?
☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Local Anesthetics ☐ Other

Do you have, or have you had, any of the following:

☐AIDS/HIY Positive
☐Alzheimer's Disease
☐Anaphylaxis
☐Anemia
☐Angina
☐Arthritis/Gout
☐Artificial Heart Valve
☐Artificial Joint
☐Asthma
☐Blood Disease
☐Blood Transfusion
☐Breathing Problems
☐Bruise Easily
☐Cancer
☐Chemotherapy
☐Chest Pains
☐Cold Sores/Fever Blisters
☐Congenital Heart Disorder
☐Convulsions
☐Cortisone Medicine
☐Diabetes
☐Drug Addiction
☐Easily Winded
☐Emphysema
☐Epilepsy or Seizures
☐Excessive Bleeding
☐Excessive Thirst
☐Fainting Spells/Dizziness
☐Frequent Cough
☐Frequent Diarrhea
☐Frequent Headaches
☐Genital Herpes
☐Glaucoma
☐Hay Fever
☐Heart Attack/Failure
☐ Heart Murmur
☐Heart Pace Maker
☐Heart Trouble/Disease
☐Hemophilia
☐Hepatitis A
☐Hepatitis *B* or C
☐Herpes
☐High Blood Pressure
☐Hives or Rash
☐Hypoglycemia
☐Irregular Heartbeat
☐Kidney Problems
☐Leukemia
☐Liver Disease
☐Low Blood Pressure
☐Lung Disease
☐Mitral Valve Prolapse
☐Pain in Jaw Joints
☐Parathyroid Disease
☐Psychiatric Care
☐Radiation Treatments
☐Recent Weight Loss
☐Renal Dialysis
☐Rheumatic Fever
☐Rheumatism
☐Scarlet Fever
☐Shingles
☐Sickle Cell Disease
☐Sinus Trouble
☐Spina Bifida
☐Stomach/Intestinal Disease
☐Stroke
☐Swelling of Limbs
☐Thyroid Disease
☐Tonsillitis
☐Tuberculosis
☐Tumors or Growths
☐Ulcers
☐Venereal Disease
☐Yellow Jaundice

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in my medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN | DATE

Medical History

Please list all medications and dosages that you take:

Medication	Dosage	Medication	Dosage

Please list all allergies:

________________________ ________________________ ________________________

Please list all medical conditions including HEART MURMURS OR DEFECTS, ARTTFICTAI VALVES OR JOINTS, AND DIABETES.

____

Signature ________________________________ Date __________________

Patient Registration

First Name: ______________________ Last Name: ______________________

Address: ____

City: ______________ State: __________ Zip Code: ______________

Home Phone: ______________ Work Phone: __________ Cellular: ______________

Birth Date: ______________ Age __________ Social Security Number ______________

Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

Employment Status ☐Full-time ☐Part-time ☐Retired

Student Status ☐Full-time ☐Part-time

Referred to this office by: ______________________

Primary Insurance Information

Name of Insured: ____

Relationship to patient: ☐Self ☐Spouse ☐Child ☐Other

Insured Social Security: ______________________ Insured Birth Date: ______________________

Employer: ______________________ Insurance Company ______________________

Address: ______________________ Address: ______________________

City, State, Zip: ______________________ City, State, Zip: ______________________

Phone Number: ______________________ Phone Number: ______________________

Secondary Insurance Information

Name of Insured: ____

Relationship to patient: ☐Self ☐Spouse ☐Child ☐Other

Insured Social Security: ______________________ Insured Birth Date: ______________________

Employer: ______________________ Insurance Company ______________________

Address: ______________________ Address: ______________________

City, State, Zip: ______________________ City, State, Zip: ______________________

Phone Number: ______________________ Phone Number: ______________________

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SIGNATURE OF PATIENT, PARENT, OR GUARDIAN DATE

INSURANCE INFORMATION AND AUTHORIZATION

OUR OFFICE IS HAPPY TO HELP YOU PROCESS YOUR INSURANCE. We will complete the form add any necessary x-rays or documentation, and mail it promptly at no charge.

Your insurance usually covers only a portion of the fee in our office. The limits of your coverage are based upon such things as premium amounts and profit margins designed by the insurance company. The insurance companies are solely responsible for these numbers. You will be asked to make your "estimated" co-payment at the time of service.

We are not members of any groups, nor do we agree to any fee schedules other than those agreed to between you and our office. When you receive treatment you agree to be financially responsible for the entire fee independent of insurance coverage. We have a very good relationship with insurance companies and will do everything we can to support your claim with the insurance company. If after "45" days from the date of service your insurance still has not paid your claim, the entire balance for that service is due and payment is expected at that time.

We will, however, continue as long as it takes, to support m any way possible your claim with the insurance company. If you have any questions regarding your account of your insurance, please do not hesitate to ask.

I authorize payment of benefits directly to the provider and the release of all necessary information to the insurance carrier and their representatives.

I have read this form and agree to be financially responsible.

Signature ______________________________________ Date ___________________

Appointment Policy

Our appointments are well planned and organized to accomplish a maximum amount of treatment in a reasonable period of time. Your appointment time, in most instances, is reserved exclusively for you and it is important that you arrive on time (preferably a few minutes earlier).

Due to the necessity of planning our appointment schedules in advance, and in fairness to our other patients, it is necessary to request at least **24 hours** notice for a change of appointment. When **24 hours** notice of a change in appointment time is given, there will be no charge for the lost appointment time. If proper notice is not given, there will be a **S25 fee**, PER SCHEDULED HALF HOUR, charged towards your account. If you find it necessary to change your appointment time, we would appreciate as much time as possible so that the time you reserved may be made available for other patients who may desire that particular time. In order to avoid interruption while treating a patient, the office manager has been given responsibility for making appointments and the collections of Fees on accounts. Please consult her concerning these matters.

I agree to this policy:___________________________ Date ____________________

Print Name____________________________________

E-mail Address: ____