HEALTH HISTORY

PATIENT INFORMATION

Name_____Birthdate_____Home Phone#_____Cell #_____

Address_____City_____State_____Zip_____Sex___M___F

__Married__Divorced__Widowed__Single__Partnered Spouse or Parent/Guardian_____

Employer_____Address_____Employer Phone #_____

Emergency Contact_____Phone #_____Relation to Patient_____

Person Responsible for Account_____Relation to Patient_____Birthdate_____

Whom may we thank for referring you?_____Physcian's Name_____#_____

DENTAL INSURANCE INFORMATION

Name of Insured_____Relation to Patient_____Phone_____

Address_____City_____State____ Zip_____SS#_____Birthdate_____

Employer_____Insurance Co._____ID#_____Group#_____

MEDICAL HISTORY

Check if you have or have had any of the following:

LIST MEDICATIONS:

___Bleeding	**___Allergy**	**___Anemia**	**___Angina**	**___Arthritis**
___Asthma	**___Cancer**	**___Diabetes**	**___Glaucoma**	**___Drug Abuse**
___Epilepsy	**___Fainting**	**___Headaches**	**___MVP**	**___Heart Condition**
___HBP	**___Pacemaker**	**___Seizures**	**___Thyroid**	**___Prosthetic Joint**
___Stroke	**___Ulcers**	**___Hepatitis**	**___HIV/AIDS**	**___Kidney Problems**
___Pregnancy	**___Radiation**	**___Sinus**	**___Emphysema**	

___Other (please list)

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LIST ALL KNOWN ALLERGIES TO ALL MEDIATIONS/LATEX/ANESTHETIC: **_____**

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To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform my doctor if I ever have a change in health. I certify that I, and/or my dependent(s), have insurance coverage with the above mentioned carrier and assign directly to Dr. Dexter all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize this as the use of my signature on all insurance submissions. Signature_____Date:_____
Relationship to patient:_____

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. THERE WILL BE A $125.00 FEE ASSOCIATED WITH ALL CANCELLED APPOINTMENTS WITHOUT 24 HOURS NOTICE.