Welcome To HWY 138 Dental

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

TODAY'S DATE:

Name_____ Birthdate_____ Home Phone: _____

Address_____ City, State, Zip _____

Sex ☐ M ☐ F ☐ Minor ☐ Married ☐ Widowed ☐ Single ☐ Separated ☐ Divorced ☐ Partnered

Social Security # _____ Cell Phone #_____

Employer/School_____Employer/School Phone _____

Employer/School Address _____City, State, Zip_____

Spouse or Parent's Name_____ Employer _____Work Phone_____

Person to contact in case of emergency_____ Phone _____

RESPONSIBLE PARTY

Name of person
Responsible for this account_____ Relation to patient_____

Address_____ City, State, Zip_____

Social Security # _____ Driver's License # _____ Birthdate _____

Home phone_____ Work Phone _____ Cell phone_____

Employer_____ Employer Address_____

Currently a patient in our office? ☐ Yes ☐ No Email address_____

INSURANCE INFORMATION

Name of insured_____ Relation to patient_____

Birthdate_____ Social Security #_____ Effective Date _____

Employer _____ Employer phone _____

Insurance Company_____ Insurance Company phone _____

Member # _____ Group # _____

HOW WERE YOU REFERRED TO US?

Please check one: ☐ Sign Outside ☐ Mail ☐ Friend or Family Member ☐ Insurance Company ☐ Our Staff

Whom may we thank for your referral? _____

I, the undersigned patient (or legally responsible party) authorize treatment to be rendered and assume financial responsibility. I acknowledge that all non-current balances on accounts over thirty days will be charged a service charge of 5% per month (18% annually) on the unpaid balance. Any additional costs incurred in collecting this account including court costs, agency fees and attorney fees will be added to my balance due.

_____
(Signature of person responsible for payment of the account)

PLEASE TURN THIS SHEET OVER AND FILL OUT THE MEDICAL HISTORY FORM

MEDICAL HISTORY

Physician's Name_____ Date of last physical_____

Have you ever had any of the following? (check all boxes that apply):

- ☐ Heart Murmur
- ☐ Angina or Heart Attack
- ☐ Congestive Heart Failure
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Problems
- ☐ Nervous Problems
- ☐ Radiation Treatment
- ☐ Artificial Valves or Joints
- ☐ Recent Weight Loss
- ☐ Back Problems
- ☐ Diabetes
- ☐ Respiratory Disease
- ☐ Emphysema
- ☐ Asthma
- ☐ Epilepsy
- ☐ Headaches
- ☐ Hepatitis Type _____
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Cancer
- ☐ Psychiatric Care
- ☐ Mitral Valve Prolapse
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicine or Drugs
- ☐ General Allergies
- ☐ Blood Disease
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Chemotherapy
- ☐ Special Diet
- ☐ Swollen Neck Glands
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ AIDS/HIV
- ☐ Thyroid Disease
- ☐ Stroke
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Chemical Dependency
- ☐ Hemophilia
- ☐ Tobacco Use
- ☐ Tuberculosis
- ☐ Other (Please specify)

_____

Is there anything else we should know about your medical history? _____

_____

Women Only:

Are you pregnant? ☐ yes ☐ no Nursing? ☐ yes ☐ no Taking birth control pills? ☐ yes ☐ no

Medications

List any medications you are currently taking

_____

_____

_____

Allergies

- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other_

DENTAL HISTORY

When did you last receive dental treatment?_____

What type of treatment?_____

Previous Dentist:_____ City, State _____

Do you have dentures, partial dentures or bridges? _____

Have you ever worn braces? _____

Have you ever had gum surgery?_____

Have you ever had any difficulty with any dental work or extractions?_____

_____