

PATIENT MEDICAL HISTORY

For Office Use Only

ID:

Patient's Name: _____ Today's Date: _____ Date of Last Visit: _____ Date of Medical History: _____

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Medications:

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Sex: _____ if female, please answer the following:

Y N	<input type="checkbox"/> <input type="checkbox"/> Are you taking Birth Control Pills? <input type="checkbox"/> <input type="checkbox"/> Are you pregnant? If Yes, # of weeks <input style="width: 30px;" type="text"/> <input type="checkbox"/> <input type="checkbox"/> Are you nursing?
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Please answer the following:

Y N	<input type="checkbox"/> <input type="checkbox"/> Do you smoke or use tobacco?
For Office Use Only	
BP: <input style="width: 50px;" type="text"/>	Heart Rate: <input style="width: 50px;" type="text"/>

Please mark Y(yes) or N(no) to all of the following:

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Sign (parent, if child) _____ Date _____ Sign _____ Date _____

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DENTAL HISTORY

1. Please tell us who to thank for referring you to our office? _____

2. What was said that helped you choose our office? _____

3. How long has it been since your last dental visit? _____
4. Have you had any unfavorable dental experiences in the past? _____

5. Is there a specific area of concern you would like Dr. Wilson to address? _____

6. Are you currently in pain? If so, where, and how painful on a 1-10 scale? _____

7. Is there anything about your smile that you would like to change? _____

8. Do you think you need a lot of dental treatment? _____
9. Do your gums ever bleed when you brush them? _____
10. Is it difficult to chew your food adequately? _____
11. Do you have any questions before we begin? _____

PATIENT INFORMATION

DATE _____

NAME _____ MARRIED SINGLE MINOR MALE FEMALE
LAST FIRST M

SOCIAL SECURITY # _____

ADDRESS _____
STREET APT.# CITY STATE ZIP

BIRTHDATE _____ TELEPHONE _____
MONTH DAY YEAR HOME WORK CELL E-MAIL

NAME OF EMPLOYER _____ ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: PATIENT GUARDIAN SPOUSE FATHER MOTHER

INSURANCE INFORMATION

MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS - COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY				SECONDARY INSURED			
LAST	FIRST	M		LAST	FIRST	M	
STREET	CITY	STATE	ZIP	STREET	CITY	STATE	ZIP
HOME	WORK	CELL	E-MAIL	HOME	WORK	CELL	E-MAIL
BIRTHDATE (MO/DAY/YEAR)		RELATIONSHIP TO PATIENT		BIRTHDATE (MO/DAY/YEAR)		RELATIONSHIP TO PATIENT	
EMPLOYER		DENTAL INS. CO		EMPLOYER		DENTAL INS. CO	
SS#	SUBSCRIBER #	GROUP #		SS#	SUBSCRIBER #	GROUP #	

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

Has any member of your family ever been treated in our office?

Yes No

Whom may we thank for referring you to our office?

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

X _____
Patient or Responsible Party

Date _____ State Driver's License # _____

METHOD OF PAYMENT

Responsible party currently has an account with this office

Yes No

Payment in full at each appointment (cash or personal check)

Payment in full at each appointment (VISA MC OTHER)

Card # _____ Exp. Date _____

I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE

If I do not pay the entire new balance within _____ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of _____% per month (or a minimum charge of \$_____ for a balance under \$_____) which is an annual percentage rate of _____% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.