

Patient Health History

Personal Information

Name: Ms. Mrs. Mr. Dr. _____

Address: _____ Phone: Home _____

City _____ State _____ Zip _____ Work _____

County _____ Cell _____

What phone number can we use to reach you during the day? _____

Employer: _____

E-Mail: _____ Sex: M F

Date of Birth: ____ / ____ / ____ Marital Status: S M D W

Patient SSN: _____

Are you a Full-Time Student? _____ Where? _____

Who is financially responsible for this account? _____

Spouse's Name: _____

Spouse's Date of Birth: ____ / ____ / ____ Spouse's SSN: _____

Insurance Information

Primary Dental Insurance Carrier: _____

Primary Insured's Name: _____

Primary Insured's SSN (or ID#): _____

Employer: _____

Group Number: _____ Insurance Co. Phone Number: _____

Address of Insurance Co.: _____

City _____ State _____ Zip _____

Secondary Dental Insurance Carrier: _____

Secondary Insured's Name: _____

Secondary Insured's SSN (or ID#): _____

Employer: _____

Group Number: _____ Insurance Co. Phone Number: _____

Address of Insurance Co.: _____

City _____ State _____ Zip _____

Dental History

Previous Dentist: _____ Phone Number: _____

Address: _____

When was your last dental appointment? _____

What treatment did you have? _____

Were X-rays taken? _____ What type? Bitewings Panorex

May we request your x-rays from your previous dentist? Yes No

MEDICAL INFORMATION

Are you currently under a physician's care? _____

If yes, name and phone number of physician: _____
(_____)_____

Are you pregnant? N/A Yes No

If yes, expected delivery date: _____

Name and phone number of physician: _____
(_____)_____

Are you currently taking any medication? _____

If yes, what type? _____

Do you have any allergies, or are you sensitive to any drugs such as Penicillin, Aspirin, Codeine, Local Anesthetics, etc? _____

If yes, what type of reactions do you have? _____

Have you ever had any of the following?

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Anemia	___	___	Heart Murmur	___	___
AIDS	___	___	Heart Problems	___	___
High Blood Pressure	___	___	Kidney Disease	___	___
Artificial Joints	___	___	Liver Disease	___	___
Asthma	___	___	Mitral Valve Prolapse	___	___
Arthritis	___	___	Panic Disorder/Anxiety	___	___
Excessive Bleeding	___	___	Other Blood Disorders	___	___
Chemotherapy (Cancer)	___	___	Rheumatic Fever	___	___
Coumadin	___	___	Surgery in past 5 years	___	___
Diabetic	___	___	Stroke	___	___
Emphysema	___	___	Epilepsy or Seizures	___	___
Strong Gag Reflex	___	___	Fainting/Convulsions	___	___
Sinus Problems	___	___	Tuberculosis	___	___
Hepatitis	___	___	Thyroid Problems	___	___
Osteoporosis	___	___			

If you checked yes for any of the above, please explain: _____

Do you require antibiotics for dental treatment? Yes No

Please list any other health information you may feel may be important. _____

Who may we thank for referring you to our office? _____

PARENT SIGNATURE

I give permission for my child to receive treatment from the doctor and staff at Dr. Richard Wilson's office. I also give permission for my child to have the appropriate x-rays taken and fluoride treatment given.

Signature: _____

Date: _____

PATIENT SIGNATURE

Deductibles and co-pays are requested and appreciated at the time services are rendered. Financial terms include cash, check, most major credit cards and pre-approved payment plans. Dental insurance is accepted, however the patient is responsible for any balance not paid by the insurance company. Delinquent accounts of 30 days or more carry a 1.5% per month service charge, with a minimum \$2.00 fee per month.

A 24 hour notification is required in the event an appointment must be cancelled. This allows the office to schedule other patients in that time slot. There may be a charge for missed appointments without proper notification.

I understand I am responsible for any collection fees, court costs, attorney fees and cancellation fees that this account may incur. I also understand and agree to the above statements.

Signature: _____

Date: _____