# Patient Medical History

Date_____

PATIENT NAME_____ SEX: M F
LAST FIRST MIDDLE

ADDRESS_____
STREET CITY STATE ZIP

MARITAL STATUS: S M W D SOCIAL SECURITY NUMBER:_____

DATE OF BIRTH:_____ EMAIL:_____

CELL PH:_____ HOME PH:_____ BUSINESS PH:_____

OCCUPATION:_____EMPLOYER:_____

PHYSICIAN NAME_____PHYSICIAN PHONE:_____

EMERGENCY CONTACT NAME:_____PHONE:_____

1. Are you under any medical treatment now? Y N If yes, what treatment? _____
2. Have you had any major operations? Y N If yes, specify _____
3. Have you had any abnormal bleeding following surgery or extractions? Y N
4. Are you taking any drugs, medicine or pills? Y N Please list _____
   _____
5. Please check any of the following that apply:

___ anxiety/depression
___ arthritis
___ artificial heart valve
___ artificial joints
___ asthma/respiratory disease
___ bisphosphonates (for osteoporosis)
___ blood thinners
___ chemo/radiation therapy
___ diabetes type 1___ 2___
___ glaucoma
___ heart attack/disease/surgery
___ hepatitis or jaundice
___ high blood pressure
___ HIV/AIDS
___ kidney disease
___ liver disease
___ mitral valve prolapse
___ pacemaker
___ rheumatic fever
___ sinus trouble
___ STDs
___ stroke
___ thyroid problem
___ tuberculosis
___ ulcer or intestinal problem

6. Are you allergic to or have you reacted adversely to:

___ local anesthesia
___ penicillin
___ sulfa drugs
___ erythromycin
___ codeine
___ aspirin or NSAIDS
___ sedatives/barbiturates
___ latex
___ other? _____

7. Women: Are you pregnant? Y N
8. How did you choose this office for your dental care?
   ___ referral (name of referral)_____
   ___ internet ___ location ___other (please specify)_____
9. When and where was your last dental visit?_____
10. When were your last full-mouth x-rays taken?_____
    Is there any condition or previous difficulty with dental treatment that we should know about prior to your treatment?_____

In compliance with the TRUTH IN LENDING LAW, our credit policy is as follows:

It is customary to take care of the fee at the time service is rendered. We accept cash, check, VISA, Master Card, Discover, and Care Credit. On reconstruction cases (crown and bridge, implants, partials and dentures) 50% of the fee is due at the time treatment begins and the balance is due before insertion.

If you have dental insurance we will accept assignment from your company provided you pay your deductible and co-payment at the time of the visit with the understanding that you are responsible for any portion not paid by your company within 60 days. A 15% APR finance charge will be assessed on all account balances over 60 days.

If we are unable to verify your coverage/benefits prior to your visit, we will ask you to pay for the visit in full and have the insurance company reimburse you directly.

## DENTAL INSURANCE INFORMATION

INSURANCE NAME:_____PHONE_____

INSURANCE ADDRESS:_____

SUBSCRIBER NAME:_____

SUBSCRIBER POLICY OR ID#:_____GROUP #_____

SUBSCRIBER EMPLOYER:_____

SUBSCRIBER SSN:_____SUBSCRIBER DATE OF BIRTH:_____

_____Accounts are considered delinquent after 60-days and will automatically be turned over to collections and 2 national credit companies unless patients have contacted our front office to make arrangements for payment in full.
I authorize release of any information to process insurance claims and collect payment for services.

Signed_____

I authorize payment of benefits directly to Davis and Ferguson Family Dentistry and understand that I am financially responsible for the charges not covered by this authorization.

Signed_____

I CERTIFY THAT THE INFORMATION I HAVE PROVIDED IS TRUE AND ACCURATE AND HAVE READ AND AGREE TO THE POLICIES LISTED ABOVE.

Signed_____Date_____

**OFFICE USE ONLY:**

| No Changes: Initial | Date | No Changes: Initial | Date |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |