

Chart #.

FOR OFFICE USE ONLY

Patient Name: Last First MI Preferred Name

Title: Mr/Ms/Mrs/etc Gender: Male Female Family Status: Married Single Child Other

Birth Date: SS #: Prev. Visit:

Email Address: Best time to call:

Phone: Home Work Ext Mobile Fax Other

Address:
 City State Zip Code

The following is for: the patient's spouse the person responsible for payment neither-not applicable

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DENTAL INSURANCE INFORMATION

Name of Insured:
Last First MI

Insured's Birth Date: ID #: Group #:

Insured's Address:

City State Zip Code

Insured's Employer Name:

Employer Address:

City State Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name:

Insurance Address:

City State Zip Code

Who may we thank for referring you to our practice?

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health?

Yes No

Within the past year, have there been any changes in your general health?

Yes No

What is the date (or approximate date) of your last medical exam?

Your Primary Care Physician's name, address, & phone number:

Please indicate if you have experienced any of the following:

- | | | | |
|-----------------------------------------------|-----------------------------------------------|---------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Allergies Anesthetic | <input type="checkbox"/> Allergies Latex | <input type="checkbox"/> Allergies Penicillin |
| <input type="checkbox"/> Allergies-See Notes | <input type="checkbox"/> Alzheimers | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Asthma/Breathing | <input type="checkbox"/> Bells Palsy | <input type="checkbox"/> Bisphosphonates HX | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chemo/Radiation Tx | <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> Coumadin |
| <input type="checkbox"/> Defibrillator | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Heart Murmur or MVP | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> HIV | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Kidney/Bladder Troub | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Needs N20-02 | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> No Epi |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Parkinsons | <input type="checkbox"/> PreMed | <input type="checkbox"/> Psychiatric Disorder |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> See Health History |
| <input type="checkbox"/> Seizre/Epilpsy/Faint | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Sulfa Allergy | <input type="checkbox"/> Thyroid Trouble | <input type="checkbox"/> Tobacco Products |
| <input type="checkbox"/> Tourette Syndrome | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcers | |

Please mark any of the following to indicate Yes in response to the question:

- Have you ever had complications following dental treatment?
- Are you currently under the care of a physician due to a specific condition?
- Have you been hospitalized within the last 5 years due to a surgery or illness?
- Do you use tobacco (smoking or chewing)?
- Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

WOMEN ONLY: Are you pregnant?

- Yes No

Please list any medications, including over the counter, that you are currently taking.

Please list all medication and food allergies you have.

What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office)?

Prior Dentist's name, address, & phone number:

If you could change anything about your mouth, teeth, or smile, what would it be?

Please mark any of the following to indicate Yes in response to the question:

- Do your gums bleed when you brush or floss?
- Do your teeth experience sensitivity to cold or hot temperatures?
- Are any of your teeth currently causing you pain?
- Do you grind your teeth (either consciously or during sleep)?
- Are any of your teeth loose, or are you concerned about any teeth loosening?
- Do you currently have any dental implants, dentures, or partials?

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

I give Edward D. Dallam, DDS my permission to discuss my dental needs with my family members if needed.

* Yes No

Names of persons Edward D. Dallam, DDS is permitted to share dental information with:

To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

Response Date: