DENTISTRY *at* GREENFIELD

DRS. DRIGGS, TURLEY & NELSON

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

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

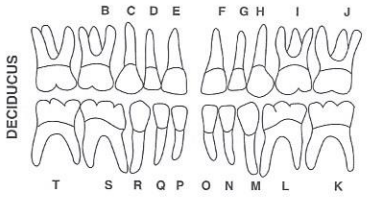
Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

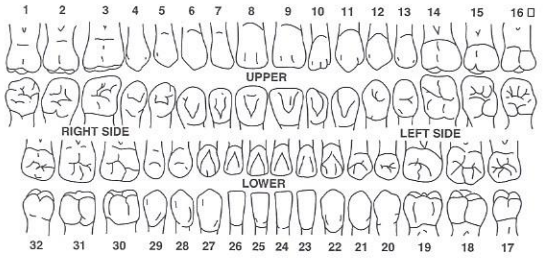
Email: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Social Security: _____

For Office Use Only





Responsible Party (If someone other than the patient)

First Name: _____ Last Name: _____ Preferred Name: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Address: _____

Primary Insurance Information

Name of Insured: _____

Relationship to above: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec.: _____

Insured Birth Date: _____

Employee ID: _____

Employer: _____

Ins. Company: _____

Ins. Phone Number: _____

Group Number: _____

Secondary Insurance Information

Name of Insured: _____

Relationship to above: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec.: _____

Insured Birth Date: _____

Employee ID: _____

Employer: _____

Ins. Company: _____

Ins. Phone Number: _____

Group Number: _____

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○ Yes ○ No If yes, please explain _____

Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes, please explain _____

Have you ever had a serious head injury? ○ Yes ○ No If yes, please explain _____

Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes, please explain _____

Do you take, or have taken, Phen-Fen or Redux? ○ Yes ○ No _____

Are you on a special diet? ○ Yes ○ No _____

Do you use tobacco? ○ Yes ○ No

Do you use controlled substances? ○ Yes ○ No

Women: Are you...
☐ Pregnant? ☐ Nursing?
☐ Taking oral contraceptives?

Are you allergic to any of the following:
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain _____

Do you have, or have you had, any of the following:

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

- **APPOINTMENTS:** *Missed appointments or appointments not cancelled within a 24 hour period will be accessed a fee of $45.00.*
- **STATEMENTS:** *All Patients, including those with insurance, will receive monthly billings until account is paid.*
- **DELINQUENT ACCOUNTS:** *Accounts over 120 days will be sent to a third party for collection.*
- **PAYMENT IS DUE IN FULL AT TIME OF TREATMENT**

_____

Signature of Patient, Parent or Guardian Date