Davey Family Dentistry

PATIENT INFORMATION

NAME_____SOCIAL SECURITY #_____ DATE_____
ADDRESS_____CITY,STATE, ZIP_____
HOME PHONE_____WORK PHONE_____CELL PHONE_____
BEST NUMBER TO REACH YOU_____EMAIL ADDRESS _____
SEX: ( ) MALE ( ) FEMALE MARITAL STATUS: ( ) SINGLE ( ) MARRIED ( ) WIDOWED ( ) DIVORCED ( ) OTHER
BIRTHDATE_____AGE _____WHOM MAY WE THANK FOR REFERRING YOU?_____
OCCUPATION_____EMPLOYER _____
SPOUSES NAME _____BIRTHDATE_____PHONE NUMBER _____

FINANCIAL/INSURANCE INFORMATION

WHO IS RESPONSIBLE FOR THIS ACCOUNT_____RELATIONSHIP TO PATIENT _____
INSURANCE COMPANY_____GROUP NUMBER_____
INSURANCE CO ADDRESS _____CITY,STATE,ZIP_____
INSURANCE COMPANY PHONE NUMBER_____INSURED NAME _____
PLAN/SUBSCRIBER NUMBER_____SOCIAL SECURITY # INSURED_____INSURED DOB_____

INSURANCE ASSIGNMENT AND RELEASE:
I Certify that I, and/or my dependent(s) have insured coverage with_____ (NAME INSURANCE CO) and assign directly to Dr. Jeremy Davey all insurance benefits any, otherwise payable to me for services rendered that I am responsible for all charges whether or not paid by insurance I authorize the use of my signature on all insurance submissions. The above named dentist may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

SIGNATURE OF RESPONSIBLE PARTY_____DATE_____
PRINT NAME_____RELATIONSHIP TO PATIENT_____

IN CASE OF EMERGENCY

PLEASE CONTACT (DOES NOT LIVE IN HOUSEHOLD)_____
RELATIONSHIP_____HOME PHONE_____CELL PHONE_____WORK PHONE _____

CONSENT FOR TREATMENT

I authorize this dental practice to administer and perform the necessary procedures, such as x-rays, anesthetics and dental treatment deemed necessary or advisable with the diagnosis of my dental condition. I understand there are certain risks inherent in dental treatment; such as but not limited to: pulpal sensitivity or damage, tissue swelling or bruising, soreness of jaws, paresthesia and other procedure specific risks.

Responsibility for Payment: I agree that should my account become delinquent, I will be responsible for all collection costs, including but not limited to the outstanding balance, attorney fees, court costs, and collection agency fees.

SIGNATURE_____ DATE _____

MINORS OR CHILDREN

Because _____ (child's name) is a minor, it is necessary that signed permission be obtained from a parent or guardian before any dental services are rendered. Such authorization is hereby granted. Furthermore, I agree to be responsible for any bills incurred on behalf of this child during their dental treatment.

SIGNATURE_____ DATE_____

MEDICAL HISTORY

PHYSICIAN'S NAME AND PHONE _____ LAST COMPLETE PHYSICAL_____

ARE YOU CURRENTLY ON ANY MEDICATIONS? ( )YES ( )NO IF YES PLEASE LIST MEDICATIONS AND PURPOSE:
_____

_____
_____
_____
_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ( )YES ( )NO IF YES PLEASE CIRCLE OR LIST:

PENICILLIN CODEINE LATEX LOCAL ANESTHETICS ASPIRIN SULFA BARBITURATES (sleeping pills)

OTHERS_____
_____

PHARMACY NAME_____ PHARMACY PHONE NUMBER_____

PLEASE CHECK YES OR NO WHICH APPLY TO YOU AND YOUR MEDICAL HISTORY:

yes	no		yes	no	
		need antibiotic coverage prior to dental work			excessive thirst and/or urination
		prior history of bacterial endocarditis			subject to fainting
		undergone radiation or IV chemotherapy			recently hospitalized or past major surgeries
		artificial joint replacement			(Women) currently pregnant - trimester?
		currently taking or ever taken bisphosphonates			(Women) currently nursing
		subject to prolonged bleeding			use or have used tobacco products in the past

PLEASE MARK YES OR NO IF YOU CURRENTLY, OR HAVE EVER BEEN DIAGNOSED OR TREATED FOR:

( )Yes( )No Acid Reflux
( )Yes( )No AIDS/HIV
( )Yes( )No Anemia
( )Yes( )No Arthritis Rheumatism
( )Yes( )No Artificial Heart Valves
( )Yes( )No Artificial Joints
( )Yes( )No Asthma/Hay Fever
( )Yes( )No Autoimmune Disorders
( )Yes( )No Back or Neck Problems
( )Yes( )No Bleeding Abnormally with extractions or surgery
( )Yes( )No Blood Disease
( )Yes( )No Blood Pressure - HIGH
( )Yes( )No Blood Pressure - LOW
( )Yes( )No Cancer Type_____
( )Yes( )No Chemotherapy
( )Yes( )No Circulatory Problems
( )Yes( )No Congenital Heart Defects
( )Yes( )No Cough (persistent or bloody)
( )Yes( )No Diabetes
( )Yes( )No Drug or Substance Abuse
( )Yes( )No Eating Disorders
( )Yes( )No Emphysema
( )Yes( )No Epilepsy or seizures
( )Yes( )No Fainting or Dizziness
( )Yes( )No Glaucoma
( )Yes( )No Headaches
( )Yes( )No Heart Murmur
( )Yes( )No Heart Problems
( )Yes( )No Hemophilia
( )Yes( )No Hepatitis Type_____
( )Yes( )No Herpes
( )Yes( )No Jaundice
( )Yes( )No Jaw Pain
( )Yes( )No Kidney Disease or Dialysis
( )Yes( )No Liver Disease
( )Yes( )No Long Term Steroid Treatment
( )Yes( )No Mitral Valve Prolapse
( )Yes( )No Nervous Problems
( )Yes( )No Osteoporosis
( )Yes( )No Pacemaker
( )Yes( )No Psychiatric Care
( )Yes( )No Radiation Treatment
( )Yes( )No Respiratory Disease
( )Yes( )No Rheumatic Fever
( )Yes( )No Scarlet Fever
( )Yes( )No Shortness of Breath
( )Yes( )No Sinus Problems
( )Yes( )No Skin Rash / Hives
( )Yes( )No Special Diet
( )Yes( )No Stroke
( )Yes( )No Swollen Feet or Ankles
( )Yes( )No Swollen Neck Glands
( )Yes( )No Thyroid Problems
( )Yes( )No Tonsillitis
( )Yes( )No Tuberculosis
( )Yes( )No Tumor or growth on Head or neck
( )Yes( )No Ulcers / Colitis

Do you have any other medical or health condition which is not listed?_____
_____

Is there anything that you prefer to talk to the Doctor in private about? ( )Yes ( )No

SIGN_____ DATE_____