SPRINGHURST HILLS
DENTISTRY

PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Patient Name_____
Last First MI (Preferred)

Birthdate_____ SS#_____ DL# _____ Gender: ! M ! F Married: ! Y ! N

Work Phone_____ Cell Phone_____Email_____

If patient is under 18 yrs, please also complete the following:

Guarantor *Name*_____
Last First MI (Preferred)

Birthdate_____ SS#_____ DL# _____ Gender: ! M ! F Married: ! Y ! N

Work Phone_____ Cell Phone_____Email_____

Student status if dependent over 19 (for ins) ! Nonstudent ! Fulltime ! Part time

How did you hear about us? (Please be specific so we can thank them!)_____

_____

ADDRESS AND HOME PHONE

Check circle if same for entire family: !

Address_____

Address 2_____

City_____ State_____Zip_____

Home Phone_____

INSURANCE POLICY 1

Patient relationship to subscriber: ! Self ! Spouse ! Child

Subscriber Name_____Sub.ID # _____Sub.DOB_____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

INSURANCE POLICY 2

Patient relationship to subscriber: ! Self ! Spouse ! Child

Subscriber Name_____Sub.ID # _____Sub.DOB_____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

Comments:_____

Please complete reverse side.

FINANCIAL AGREEMENT

* For my convenience, this office may release my information to my insurance, and receive payment directly from them.
* If sent to collections, I agree to pay a **$30 collection fee**, all related fees and court costs.
* Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
* Treatment plans may change, and I will be responsible for the work actually done.

Signature_____ Date_____

MEDICAL HISTORY

Name of Medical Doctor:_____ City/State_____

Emergency Contact_____ Phone_____Relationship_____

List all the medications or drugs you are now taking:

[ ] None

_____

_____

_____

_____

Check medications or drugs you are allergic to:

! None
! Aspirin
! Codeine/ Other Narcotics
! Erythromycin
! Latex Rubber
! Local Anesthetics
! Metals
! Penicillin
! Sulfa Drugs
! Other: _____

Check any medical conditions you may have:

! None	! Diabetes	! Joint Replacement, Date of: _____
! AIDS/HIV	! Emphysema	! Kidney/Bladder Trouble
! Alcohol/Drug Abuse	! Epilepsy	! Liver Disease
! Anemia/Leukemia	! Fainting Spells/Seizures	! Low Blood Pressure
! Anorexia/Bulimia	! Fever Blisters/Herpes	! Mental Health Problems
! Arthritis	! Frequent Headaches	! Mitral Valve Prolapse
! Asthma/Hay Fever	! Frequently Dry Mouth/Sjogren	! Persistent Diarrhea
! Blood Clotting Problems	! Gall Bladder Trouble	! Rheumatic Fever
! Blood Transfusion	! Heart Attack/Stroke	! Rheumatic Heart Disease
! Bronchitis	! Heart Disease/Angina	! Sexually Transmitted Disease
! Cancer/Tumor or Growth	! Heart Murmur	! Sinus Trouble
! Cardiac Pacemaker	! Hepatitis/Jaundice	! Stomach Ulcers
! Chest Pain Upon Exertion	! High Blood Pressure	! Thyroid Problems
! Damage Heart Valve	! Hives/Skin Rash	! Tuberculosis

! Other: _____

WOMEN ONLY- Are you pregnant or do you have reason to believe you may be? ! Yes / ! No

Tobacco use? If so, what kind and how much?_____

Unusual reaction to dental injections?_____

Reason for today's visit:_____ Are you in pain? Yes / No

New patients:

Name of former dentist_____ City/State_____

Date of last cleaning and exam_____

By signing below, I certify that all of the above information is true to the best of my knowledge.

_____ _____

Patient/Guardian Name (printed) Date

_____

Patient/Guardian Signature