

*Welcome*

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us. We will be happy to help.

Email Address \_\_\_\_\_ Date: \_\_\_\_\_  
Prefer  AM or  PM appointments Soc. Sec. # \_\_\_\_\_

**Patient Information (CONFIDENTIAL)**

Name \_\_\_\_\_ (nickname) \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Check appropriate Box  Minor  Single  Married  Divorced  Widowed  Separated

Patient's or Parent's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

If Patient is a Student. Name of School / College \_\_\_\_\_ F/T  P/T  City \_\_\_\_\_ State \_\_\_\_\_

Whom May We Thank for Referring You? \_\_\_\_\_

Person to contact in case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_

**Responsible Party**

Name of Person Responsible for this Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Soc. Security # \_\_\_\_\_ Birthdate \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Is this Person Currently a Patient in our Office?  Yes  No

**Dental Insurance Information**

**Primary Insurance**

**Secondary Insurance**

Name of Insured \_\_\_\_\_

Name of Insured \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Insured's birthdate \_\_\_\_\_

Insured's birthdate \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_

Employer \_\_\_\_\_

Employer \_\_\_\_\_

Date Employed \_\_\_\_\_

Date Employed \_\_\_\_\_

Occupation \_\_\_\_\_

Occupation \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Company \_\_\_\_\_

Group # \_\_\_\_\_

Group # \_\_\_\_\_

**Please Read and Sign**

I authorize payment to Jeff T. Blackburn, DDS, for the benefit otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all the charges arising for the treatment of the above named patient. If this contract is referred to an attorney for collection, I agree to pay attorney's fees and the total indebtedness and court costs incurred by Jeff T. Blackburn, DDS. If this indebtedness is not paid in full within thirty (30) days from the last date of service, I agree to pay a service charge of one and one-half (1 & 1/2) percent per month, eighteen (18) percent interest per annum on the unpaid balance.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

(MORE QUESTIONS ON BACK)

**MEDICAL HISTORY:**

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

	YES	NO		YES	NO
Heart Murmur			Frequent Headaches		
Rheumatic Fever			X-ray Therapy		
Heart Attack / Ailment			Tumors, Cysts or Cancer		
High Blood Pressure			Prolonged Bleeding		
Artificial Joints or Valves			Healing Complications		
Diabetes			Ear Problems		
Epilepsy			Nervous or Mental Disorders		
Tuberculosis			Venereal Disease		
Respiratory Disease			AIDS, or AIDS Related Complex		
Asthma			Hepatitis, Yellow Jaundice or		
Fainting Spells			Liver problems		

Do you have a history of cold sores or oral ulcers? \_\_\_\_\_

Are you allergic to any drug? \_\_\_\_\_ Specify \_\_\_\_\_

Are you currently taking any drugs or medications? \_\_\_\_\_ Specify \_\_\_\_\_

Do you have any general health problems? \_\_\_\_\_ Specify \_\_\_\_\_

Are you currently under a physicians care? \_\_\_\_\_

Have you had any major operations? \_\_\_\_\_ Specify \_\_\_\_\_

Have you been hospitalized in the past 2 years? \_\_\_\_\_

Are you pregnant? \_\_\_\_\_

Who is your physician? \_\_\_\_\_

When was the last time you were examined by your physician? \_\_\_\_\_

PATIENT'S or GUARDIAN'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**DENTAL HISTORY:**

What is your present dental complaint: \_\_\_\_\_

What is your dental health:      Excellent      Good      Fair      Poor

On a scale of 1-10, (1 being lowest), what priority do you give your teeth? \_\_\_\_\_

Are your teeth sensitive to hot, cold, sweets or biting pressure? \_\_\_\_\_

Do you clench or grind? \_\_\_\_\_

Have you ever had any injuries to your face or jaw? \_\_\_\_\_

Do some teeth seem to strike before others when closing? \_\_\_\_\_

Do any teeth feel loose? \_\_\_\_\_

Have your gums ever been treated? \_\_\_\_\_

Do your gums bleed when you brush? \_\_\_\_\_

Do you floss? \_\_\_\_\_ How often? \_\_\_\_\_

When was your last dental appointment? \_\_\_\_\_

Have you ever experienced any problems with a dental injection? \_\_\_\_\_

Are you extremely nervous during or prior to dental appointments? \_\_\_\_\_

Are you interested in Brightening Your Smile? \_\_\_\_\_

Is there anything else you want to tell us about your dental or medical health? \_\_\_\_\_

**CANCELLATION POLICY:**

Our office requires at least 24 hours notice if you must cancel an appointment. If less notice is given a fee for the appointment time and preparation may be charged. Your appointments require much preparation and we reserve time especially for you at that appointment. Please respect our time as we try very hard to respect yours. Thank You.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FORM MUST BE COMPLETED OR TREATMENT MAY BE DENIED**