

Patient Information

NAME _____ DOB _____ SEX M F HOW DID YOU HEAR ABOUT US? _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME # _____ MOBILE# _____ PATIENT'S SSN _____

PATIENT'S PLACE OF EMPLOYMENT _____ WORK# _____ EMAIL: _____

SPOUSE OR PARENTS NAME _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT _____

INSURANCE COMPANY _____

PRIMARY INSURED NAME _____ PRIMARY'S SSN _____

PRIMARY'S DOB _____

When was your last dental exam? _____ How often do you brush your teeth? _____

Do you have pain in any part of your mouth? _____ Do you have any headaches, popping, or clicking when you chew? _____ Are you completely happy with the appearance of your teeth? _____

INTERESTED IN			
Nitrous (Laughing Gas)	<input type="checkbox"/>	Oral Cancer Screening	<input type="checkbox"/>
Sedation	<input type="checkbox"/>	Whitening	<input type="checkbox"/>
Orthodontics	<input type="checkbox"/>	Botox/ Fillers	<input type="checkbox"/>
Implants	<input type="checkbox"/>	Skincare	<input type="checkbox"/>
Same-day Crowns/Veneers	<input type="checkbox"/>		

I authorize release of information on dental claims to insurance company

I assign insurance benefits to Keith A. Dillard, DMD unless otherwise specified

Signature _____

Signature _____

+ MEDICAL HISTORY

Care of Physician, Name _____ Contact # _____

AIDS/ HIV Artificial Joints Cancer

Tobacco Use Asthma Radiation/Chemo Treatment

Arthritis Diabetes Stroke

Heart Problems Seizures Sinus Trouble

Artificial Heart Valve Hepatitis Thyroid

Murmur Venereal Disease Tuberculosis

Back Problems High Blood Pressure Stomach

Chemical Dependency Kidney Disease Pregnant, Due Date _____

Transfusion Premedicate Psychiatric Care

MEDICATIONS- _____

SURGERIES _____

ALLERGIES

Aspirin Erythromycin Penicillin Other: _____

Codeine Latex Sulfa _____

Anesthetics Metals Tetracycline _____

The answers on this form, have been accurately answered. I understand that providing incorrect

information can be dangerous to my (or patient's) health.

★ Please indicate your selection below via signature

I choose the optimal option for my patient care _____ I choose the insurance discount option for my patient care _____