

PATIENT INFORMATION

Full Name _____ Date of Birth _____ Martial Status _____

Home Address _____ City _____

State _____ Zip _____ Social Security # _____

Home Phone _____ Cell Phone _____

Work Phone _____ E-mail Address _____

Please indicate if you want e-mail updates from Parker Dental? Yes _____ No _____

Employer & Address _____

Insurance Company's Name _____

Address _____

Group # _____ Phone _____

How did you choose this office: () Personal referral by _____

() Yellow Pages () Sign () Advertisement () Website () Other

RESPONSIBLE PARTY INFORMATION

(if different from above information or if co-insurance/secondary insurance)

Full Name _____ Date of Birth _____

Home Address _____ City _____

State _____ Zip _____ Social Security # _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer & Address _____

Insurance Company's Name _____

Address _____

Group # _____ Phone _____

MEDICAL INFORMATION

CIRCLE YOUR RESPONSE

Are you currently under medical care? YES NO

If so, for what? _____

Do you have allergies? YES NO

If so, what are they? _____

Do you take medication? YES NO

If so, what are they? _____

Are you pregnant? YES NO

PLEASE CONTINUE ON NEXT PAGE

- Do you or have you ever had any of the following:
- | | |
|--|--|
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Latex Allergies |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Heart Ailment | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Herpes Infection |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stomach Disorder |
| | <input type="checkbox"/> Tuberculosis |
| | <input type="checkbox"/> Hepatitis or Jaundice |
| | <input type="checkbox"/> Alcoholism |
| | <input type="checkbox"/> Drug Addiction |
| | <input type="checkbox"/> A.I.D.S. |

Is there any other medical information that we should be aware of? _____

DENTAL INFORMATION

CIRCLE YOUR RESPONSE

- | | | | |
|--|--------|-------------|------------|
| Are you experiencing any pain in your teeth or gums? | YES/NO | Gums Bleed? | YES/NO |
| Do you have pain in your joints near your ears? | YES/NO | Bad Breath? | YES/NO |
| Do you habitually grind or clench your teeth? | YES/NO | | |
| Do you have growths or lesions in your mouth? | YES/NO | | |
| Are you happy with the appearance of your teeth? | | | |
| | YES | SOMEWHAT | NOT AT ALL |

- Are you apprehensive about dental treatment?
- YES SOMEWHAT NOT AT ALL

Please make any additional comments that may be a concern to you: _____

In case of an emergency, notify _____ Phone _____

I understand and agree that payment is required regardless of my insurance status. If one's insurance has not been paid within 60 days, I am ultimately responsible for the balance on my account for any professional services rendered. Balances over 90 days from date of service will be subject to a \$15.00 monthly fee. In the event of collection procedures the patient (or responsible party) will be liable for any associated fees such as attorney fees, court cost, etc. I have read all the information on this questionnaire and completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature (parent if patient is a minor)

Date

