Blankenship Dental Care—History form

Please fill out and sign

Patient's name_____

Marital status: Single__, Married__, Divorced__, Child__ Sex: _____ (M/F)

Parent's name: (if child) _____

Mailing address: _____

City: _____, State: _____, Zip: _____, County: _____

Home address: (if different) _____

City: _____, State:_____, Zip:_____, County:_____

Patient's SS#____-___-_____, Birth date: ____/_____/____ Email:_____

Home phone: ( ) _____, Cell: ( ) _____, Work: ( ) _____

Emergency contact: (name and relationship) _____

Their phone: ( ) _____ Alternate contact: _____

Your employer: (or father's if child) _____

City: _____, State: _____, Zip: _____

Spouse's employer: (mother's if child) _____

City: _____, State: _____, Zip: _____

Account responsible party: (if not patient) _____

Is the patient covered by dental insurance? _____

If yes, name of insured: _____SS#____-___-_____

Relationship to patient: Self___, Spouse___, Mother ___Father___, Their Birthdate: ___/___/____

***Please present insurance information to receptionist with this form***

**Please sign below if you wish to have insurance payments sent to us. If not, payment in full is due at the time of treatment.**

**Signature on file:**_____

Account balance will be paid by: Cash: __, Check: ____, Credit/Debit card: ___

All financial arrangement must be made in advance. We will provide fee estimates on request. We request co-pay on insurance claims at the time of service. A finance charge of 1.5% per month will be added to the unpaid balance of 90 days or more. Accounts become past due 30 days after first billing. The account responsible party will be responsible for payment of interest and any reasonable fees associated with collection of a past due account, including but not limited to collection service fees or attorney costs that may include court costs, etc. We reserve the right to charge for broken appointments at our discretion.

I have read and understand the above information and agree to the terms noted. I personally completed the information requested and attest that it is correct.

Signed: _____ (parent or guardian if child) Date: _____

**Medical Information** **Patient's name:** _____ **Date:** _____

Physician: _____ City: _____ Phone: (  ) _____

Do you have a history of any of the following conditions?

| | | | |
|---|---|---|---|
| __Anemia | __Other allergies | ___ Joint replacement | ___other |
| __Diabetes (Type 1) | __Abnormal heart condition | ___Pacemaker/defibrillator | |
| __Diabetes (Type 2) | __Abnormal bleeding | ___Stroke | |
| __Hepatitis A, B, C (___) | __Venereal disease | ___Reflux (GERD) | |
| __Heart murmur | __High blood pressure | ___Tuberculosis | |
| __High cholesterol | __Major Surgery | ___Arthritis | |
| __Use tobacco | __Cancer | ___Fever blisters | |
| __Drug allergies | __AIDS/HIV positive | ___Vertigo (dizziness) | |

Please give more information for any checked items:

_____

_____

_____

Please list all medications, including over the counter products: (or current list if available)

1._____for_____

2._____for_____

3._____for_____

4._____for_____

5._____for_____

Ladies: Are you pregnant? _____ If yes, how many months? ____

Home water source: City____ Well_____

**Dental Information:**

Are you in pain from your teeth or jaws? _____, if so where? _____

Have you had any of the following dental treatments?

____Orthodontics (braces) ____Oral surgery (extractions, implants, etc.) ____Endodontics (root canals)

____Periodontics (gum therapy) ____other (non-routine)

Any significant injuries/surgeries to your face, teeth, mouth? _____

Do your gums bleed or your teeth feel loose? _____

Do your jaws (TMJ's) click, pop or hurt? ____ Do you grind your teeth at night? _____

Do you have any problems chewing your food? ____ Do you wear removable appliances? _____

Are you satisfied with your dental appearance? _____

Date of last dental care? _____ Previous dentist _____

Purpose of today's visit? _____

Whom may we thank for your referral? _____