Davisson Dental

Patient Information and Medical History

Patient's Name____ Male Female

(Last) (First) (Middle)

Telephone: (home)______________________ (work)_______________ (cell)_______________

Email Address ____

Birth Date __/__/____ Social Security Number ____-____-____ Preferred Name: ______________

Street Address ______________________________________ Apt. /Suite ________

City ______________________________ State ______________ Zip______________

Responsible Party Name: ________________________________ Male Female

(Last) (First) (Middle)

Telephone: (home)______________________ (work)_______________ (cell)_______________

Email Address ____

Birth Date __/__/____ Social Security Number ____-____-____

Street Address ______________________________________ Apt. /Suite ________

City ______________________________ State ______________ Zip______________

Insurance Information

Primary Insurance

Employer Name ______________________________

Employer Address ______________________________ Employer Phone#______________

Insured Name	DOB	SSN:
Relationship to Insured	Group #	
Insurance Company	Insurance Co Phone #	

Secondary Insurance

Employer Name ______________________________

Employer Address ______________________________ Employer Phone#______________

Insured Name	DOB	SSN:
Relationship to Insured	Group #	
Insurance Company	Insurance Co Phone #	

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends on reimbursement from the patients for the cost incurred in their care and financial responsibility on the part of each dental patient must be determined before treatment.

All emergency dental services, or any dental services performed without financial arrangements, must be paid in cash/credit card at the time services are performed.

Patients who carry dental insurance understands that all dental services furnished are charged directly to the patient and that he or she is *personally responsible* for the payment of all dental services. This office will help prepare the insurance forms or assist in making collections from the insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by the insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the value of the said services to said Doctor, or his/her assigns, at the time said services are rendered, or within five (5) days for billing if credit shall be extended. I further agree that the value of the said services shall be billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and further agree to pay all cost and reasonable attorney fees if a suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss related matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

______________________________ Date:______________ Relationship to Patient: ________

Signature of patient, parent or guardian

______________________________ Date:______________ Realtionship to Patient: ________

Signature of patient, parent or guardian

Emergency Contact: (Closest family member not living with you)

Name ____________________ Telephone ____________________

Address ____________________ Relationship ____________________

Health History

What is the name of your physician? ____________________

Physician Address ____________________

Physician Phone # ____________________

Have you ever had any of the following? Please circle those that apply:

AIDS	Diabetes	Heart Attacks	Pregnancy	Tumors
Dizziness	Heart Murmur		Due Date_______	Ulcer
Epilepsy	Hepatitis	Radiation Treatment	Venereal Disease	
Anemia	Excessive Bleeding	High Blood Pressure	Respiratory Problems	Codeine Allergy
Arthritis	Fainting	Jaundice	Rheumatic Fever	Penicillin Allergy
Artificial joints	Glaucoma	Kidney Disease	Rheumatism	Other Allergies:
Asthma	Growths	Liver Disease	Sinus Problems	____________
Blood Disease	Hay Fever	Mental Disorder	Stomach Problems	____________
Clotting Disorder	Head Injuries	Nervous Disorders	Stroke	____________
Cancer	Heart Disease	Pacemaker	Tuberculosis	____________

List ALL Medications:

Drug:	**Qty:**	**Drug:**	**Qty:**
Drug:	**Qty:**	**Drug:**	**Qty:**
Drug:	**Qty:**	**Drug:**	**Qty:**

Dental History

Do you visit the dentist regularly?	Yes	No
Do your gums bleed?	Yes	No
Do you want to keep your remaining teeth?	Yes	No
Do you smoke or chew tobacco?	Yes	No
Do you have any sore spots in your mouth?	Yes	No
Are your teeth sensitive?	Yes	No
Do you suffer with migraines or other forms of headaches?	Yes	No
Do your jaws pop or click when you eat? Clench?	Yes	No
How do you feel about your teeth 10-highest/ 1-lowest	1 2 3 4 5 6 7 8 9 10	

Please describe your specific dental problem:____________________

How were you referred to our practice?

o	Another Patient, Friend	List Name:
o	Another Patient, Relative	List Name:
o	Other Medical /Dental Office	
o	Yellow Pages	
o	School	
o	Work/Insurance Plan	
o	Advertisement / Coupon	
o	Internet How did you search for us? (Ex: Springboro Dentist)	

Would you like to be included in our email/text messaging program for appointment reminders and specials? Yes No

To the best of my knowledge, all of the preceding answers and information are true and correct. I shall inform the staff and the doctor about my changes in my health status at each appointment without fail.

Patient /Parent/Guardian Signature

____________________ Date____________________