

PATIENT INFORMATION

Date: _____

Marital Status: Single ___ Married ___
Separated ___ Divorced ___ Widowed ___

Name: _____ Male ___ Female ___

Mailing Address: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____

County: _____ Driver's License #: _____

Date of Birth: _____ SS#: _____ Home Phone #: _____

Email Address: _____ Name of School: _____

Employer: _____ Work Phone #: _____ Cell #: _____

Mailing Address: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____

Spouse's Name or (If a minor) Parent's Name: _____

Date of Birth: _____ SS#: _____

Employer: _____ Work Phone #: _____ Cell #: _____

Mailing Address: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____

Other Parent's Name (If a minor): _____

Date of Birth: _____ SS#: _____

Employer: _____ Work Phone #: _____ Cell #: _____

Mailing Address: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____

Responsible Party's Name for Billing Purposes: _____

(Complete if different from patient's address listed above.)

Mailing Address: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____

DENTAL INSURANCE

Plan I (Primary) Dental Insurance

Name of Insured/Employee: _____ Policy or Subscriber ID#: _____

Dental Insurance Company: _____ Plan or Group #: _____

Phone # for Eligibility Verification: _____ Ext #: _____ Contact Person: _____

If additional insurance may be used, please complete Plan II information:

Plan II (Secondary) Dental Insurance

Name of Insured/Employee: _____ Policy or Subscriber ID#: _____

Dental Insurance Company: _____ Plan or Group #: _____

Phone # for Eligibility Verification: _____ Ext #: _____ Contact Person: _____

Have you or another member of your family been treated here? ___ If so, who? _____

Who can we thank for referring you to our office? _____

***** IN CASE OF EMERGENCY *****

Name: _____ Phone #: _____ Cell #: _____

(Please list closest relative or friend whose address is different from yours.)

Mailing Address: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____

What would you like to change about the appearance of your teeth and smile?

What problems or concerns do you have with your teeth or gums? _____

HEALTH HISTORY

Have you ever had a frightening experience with dentistry? If so, explain. _____

Has there been any problem in your general health (serious illness, hospitalization, surgery)? If yes, please explain.

Medical Doctor _____ The date of your last medical check-up. _____

What medications, tablets, pills, or liquids do you take? _____

(that includes aspirin, vitamins, tonics, birth control pills, etc.)

Check any of the following which you have had or have at present (✓)

- | | | |
|---|---|--|
| <input type="checkbox"/> <i>Heart Failure</i> | <input type="checkbox"/> <i>Cough</i> | <input type="checkbox"/> <i>Hepatitis A (Infectious)</i> |
| <input type="checkbox"/> <i>Heart Disease or Attack</i> | <input type="checkbox"/> <i>Strokes</i> | <input type="checkbox"/> <i>Hepatitis B (Serum)</i> |
| <input type="checkbox"/> <i>Angina Pectoris</i> | <input type="checkbox"/> <i>Asthma</i> | <input type="checkbox"/> <i>Liver Disease</i> |
| <input type="checkbox"/> <i>High Blood Pressure</i> | <input type="checkbox"/> <i>Hay Fever</i> | <input type="checkbox"/> <i>Yellow Jaundice</i> |
| <input type="checkbox"/> <i>Heart Murmur</i> | <input type="checkbox"/> <i>Sinus Trouble</i> | <input type="checkbox"/> <i>Blood Transfusion</i> |
| <input type="checkbox"/> <i>Rheumatic Fever</i> | <input type="checkbox"/> <i>Drug Addiction</i> | <input type="checkbox"/> <i>Allergies or Hives</i> |
| <input type="checkbox"/> <i>Congenital Heart Lesions</i> | <input type="checkbox"/> <i>Diabetes</i> | <input type="checkbox"/> <i>Hemophilia</i> |
| <input type="checkbox"/> <i>Scarlet Fever</i> | <input type="checkbox"/> <i>Arthritis</i> | <input type="checkbox"/> <i>Venereal Disease</i> |
| <input type="checkbox"/> <i>Artificial Heart Valve</i> | <input type="checkbox"/> <i>Chemotherapy</i> | <input type="checkbox"/> <i>Cold Sores</i> |
| <input type="checkbox"/> <i>Heart Pacemaker</i> | <input type="checkbox"/> <i>Anemia</i> | <input type="checkbox"/> <i>Genital Herpes</i> |
| <input type="checkbox"/> <i>X-ray or Cobalt Treatment</i> | <input type="checkbox"/> <i>Rheumatism</i> | <input type="checkbox"/> <i>Tuberculosis (TB)</i> |
| <input type="checkbox"/> <i>Thyroid Disease</i> | <input type="checkbox"/> <i>Heart Surgery</i> | <input type="checkbox"/> <i>Artificial Joint</i> |
| <input type="checkbox"/> <i>Epilepsy/Seizures</i> | <input type="checkbox"/> <i>Glaucoma</i> | <input type="checkbox"/> <i>Nervousness</i> |
| <input type="checkbox"/> <i>Fainting or Dizzy Spells</i> | <input type="checkbox"/> <i>Kidney Trouble</i> | <input type="checkbox"/> <i>Cortisone</i> |
| <input type="checkbox"/> <i>Psychiatric Treatment</i> | <input type="checkbox"/> <i>Ulcers</i> | <input type="checkbox"/> <i>Sickle Cell Disease</i> |
| <input type="checkbox"/> <i>Pain in Jaw Joints-TMJ</i> | <input type="checkbox"/> <i>Headaches/Migraines</i> | <input type="checkbox"/> <i>Bruise Easily</i> |
| <input type="checkbox"/> <i>WOMEN: Are you pregnant?</i> | <input type="checkbox"/> <i>Snore</i> | <input type="checkbox"/> <i>Redux, FenPhen</i> |
| <input type="checkbox"/> <i>Mitral Valve Prolapse</i> | <input type="checkbox"/> <i>Daytime Sleepiness</i> | <input type="checkbox"/> <i>Fosomax</i> |
| <input type="checkbox"/> <i>Emphysema</i> | <input type="checkbox"/> <i>AIDS/ARC</i> | |

Do you have any diseases, conditions, or problems not listed above the doctor should know about?

Sensitive or allergic to: Penicillin _____ Codeine _____ Novocaine _____ Aspirin _____ None _____

Other _____

PERMISSION FOR TREATMENT AND PROMISE OF PAYMENT

This is to certify that I, the undersigned, consent to the performance of any and all procedures, and the use of any and all drugs that are agreed to be necessary or advisable. I also agree to accept full responsibility for the payment of all fees associated with this family account, the procedures or drugs, all costs incurred in the collection of those fees, and interest on unpaid balance. I hereby authorize payment of the dental benefits otherwise payable to me to Dr. Peele. I have been offered a copy of this office's notice of Privacy Practices.

Signature _____ Date _____
