John A. Hendry, D.D.S.
Kathleen Adley Darnall, D.D.S.

& Associates

A PROFESSIONAL DENTAL CORPORATION

Today's Date: ________________

I. Patient Information

Language preferred: English or list other:____________________________________
(circle)

Name (last) __________________________ (first) ______________________________ (middle) _______________

** If patient is a minor, give name of parent/guardian: ____

Sex: Male or Female (circle one) ☐ Married ☐ Single ☐ Divorced

Address ____________________________________ ________________________ _____ __________
Street City State Zip

Home #:_______________________ Birthday: ________________ Social Security #:_______________________

Cell#: ________________________ Email address: ____

Employer: ______________________ Occupation: __________________Work phone #:___________________

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Spouses Name (last) ________________________ (first) ________________________ (middle) _____________

Cell#: ________________________ Email address: ____

Employer: ______________________ Occupation: __________________Work phone #:___________________

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Reason for appointment today: ☐ Check up & cleaning ☐ Toothache ☐ other ______________________

Whom may we thank for referring you to our office? ____

II. Emergency Information

Name of nearest relative not living with you____

Address_______________________________________ Phone #_________________ Relationship____________

Name of nearest friend not living with you____

Address_______________________________________ Phone #_________________ Relationship____________

III. Responsible Party for Payment of Account *(if different from patient info above)*

Name (last) ____________________________ (first) ___________________________ (middle) ______________

Mailing Address _________________________________ _____________________ ______ __________
Street City State Zip

Home #: ______________________ Birthday: ________________ Social Security #:______________________

Cell#: ________________________ Email address: ____

Employer:________________________ Occupation: __________________ Work phone#:__________________

Relationship to Patient: ___________________________

IV. *Payment options for Professional Fees*

1. Pre-payment of all dental care to be rendered
2. Cash / check
3. Visa, Master Card, American Express, Discover
4. Care credit
5. Insurance ***(we need copy of insurance card to file ALL insurance claims)***

Subscriber's Name ___________________________________

Subscriber's SS#______________________________________ *(if different from patient info above)*

Subscriber's date of birth________________________________ *(if different from patient info above)*

Subscriber's Employer: ____

Group # ___________ *(if not listed on insurance card)*

V. *Medical History* ***Do you have any of the following?***

☐ Allergies (seasonal)
☐ Alzheimer's/Dementia
☐ Aspirin Allergy
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Autism
☐ AIDS/HIV
☐ Excessive Bleeding
☐ Glaucoma
☐ History of MRSA/Staph infections
☐ Heart Attack
☐ Heart Disease / Abnormalities
☐ Heart Murmur ________________
☐ Hepatitis
☐ Head Injury
☐ High Blood Pressure
☐ Sinus problems
☐ Stroke / Chest pain
☐ Stomach Troubles / Ulcers
☐ Swollen ankles
☐ Sexually transmitted disease
☐ Sickle Cell Anemia
☐ Tuberculosis
☐ Taking aspirin daily
☐ Thyroid problems

☐ *Allergic to* (food, etc) ________________/________________/________________/________________

☐ Anxiety / Depression
☐ Blood Disease
☐ Cardiac Pacemaker
☐ Chemotherapy
☐ Crohn's Disease
☐ Codeine Allergy
☐ Drug Addiction
☐ Diabetes: Type ____
☐ Dizziness / Fainting
☐ Epilepsy ☐Seizures
☐ Emphysema
☐ Eczema
☐ Hay Fever
☐ Joint Replacement or Implant
☐ Kidney Disease / Problems
☐ Leukemia
☐ Liver Disease / Problems
☐ Low Blood Pressure
☐ Allergy to Latex
☐ Mitral Valve Prolapse
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Recent Weight Loss
☐ Radiation Treatment
☐ Temperature sensitivity
☐ Psychiatric Care
☐ ADD / ADHD
☐ COPD
☐ Cancer: ________________
____
☐ Other: __________________
____
☐ Jaw popping/clicking/locking
☐ Chewing discomfort

1. Are you under medical treatment now? Yes No
   If yes please explain: ____
2. Are you taking any medication(s), including non-prescription? Yes No
   If yes please list: ___________________ ________________________ ________________________
   ___________________ ________________________ ________________________
3. Do you use tobacco products of any kind? Yes No please advise: ______________________________
4. Do you wear contact lenses? Yes No
5. Are you allergic to or have had any reactions to the following? ***please circle all that apply***

Local Anesthetics (Novocaine, Lidocaine, Codeine) / Penicillin, Amoxicillin or other antibiotic / Sulfa Drugs

Sedatives / Barbiturates / Aspirin / Any metals (nickel, mercury, etc) / Latex Rubber / Iodine / Red Dye

Other (please list) ____ / *NONE*

Medical History con't

6. Have you ever taken an Osteoporosis medication? No or circle > *Fosamax / Actonel / Boniva / Aredia / Zometa*

   Other: _________________________________ *Date started:* ____________ *Date stopped:* ____________

7. Have you ever had IV treatment for cancer? No or Yes

   Date started: ____________ *Date stopped:* ____________

8. Have you been admitted to the hospital or needed emergency care during the past 2 years? No or please explain

   If yes, please explain: ____

For Women Only:

Are you taking birth control pills? Yes or No

Are you pregnant or think you may be pregnant? Yes or No

VI. Patient Dental History

1. Do your gums bleed while brushing or flossing? Yes No
2. Are your teeth sensitive to hot/cold/sour liquids/foods? Yes No
3. Do you feel pain to any of your teeth? Yes No
4. Do you have any sore or lumps in or near your mouth? Yes No
5. Have you had any head, neck or jaw injuries? Yes No
6. Have you owned any of the following appliances Yes No

   ☐NTI-Night Guard ☐Snoring Appliance ☐CPAP ☐Retainer

   How often do you wear the appliance? ______________________

7. How often do you awaken with head/jaw pain of unknown origin?

   ☐Every morning ☐Once or twice a week ☐Few times a month ☐Never

8. Have you ever had any prolonged bleeding? Yes No
9. Have you ever had any prolonged bleeding following extractions? Yes No
10. Have you ever had any orthodontic treatment? Yes No
11. Do you like your smile? Yes No- please explain: ____

12. Date of your last dental exam/cleaning: _____________________ @ Dr. ______________________________

13. Where x-rays taken at that appointment? Yes No

VII. Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and or health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on my dependents behalf.

X____ ________________________________

Signature of Patient (or parent if minor) *(Relationship to patient if minor)*