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

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 will <u>need copy of insurance card</u> to file claims)***

Insured's Name _____

Insured's SS#_____ *(if different from patient info above)*

Insured's date of birth_____ *(if different from patient info above)*

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

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

☐ Allergies (seasonal)	☐ Excessive Bleeding	☐ Sinus problems
☐ Alzheimer's/Dementia	☐ Glaucoma	☐ Stroke / Chest pain
☐ Aspirin Allergy	☐ History of MRSA/Staph infections	☐ Stomach Troubles / Ulcers
☐ Anemia	☐ Heart Attack	☐ Swollen ankles
☐ Arthritis	☐ Heart Disease	☐ Sexually transmitted disease
☐ Artificial Joints	☐ Heart Murmur	☐ Sickle Cell Anemia
☐ Asthma	☐ Hepatitis / Jaundice	☐ Tuberculosis
☐ Angina	☐ Head Injury	☐ Taking aspirin daily
☐ AIDS/HIV	☐ High Blood Pressure	☐ Thyroid problems
☐ *Allergic to* (food, etc) _____/_____/_____/_____		
☐ Anxiety / Depression	☐ Hay Fever	☐ Chewing discomfort
☐ Blood Disease	☐ Joint Replacement or Implant	☐ Temperature sensitivity
☐ Cardiac Pacemaker	☐ Kidney Disease	☐ Psychiatric Care
☐ Chemotherapy	☐ Leukemia	☐ COPD
☐ Crohn's Disease	☐ Liver Disease	☐ ADD / ADHD
☐ Codeine Allergy	☐ Low Blood Pressure	☐ Cancer: _____
☐ Drug Addiction	☐ Allergy to Latex	_____
☐ Diabetes: Type ____	☐ Mitral Valve Prolapse	☐ Other: _____
☐ Dizziness / Fainting	☐ Respiratory Problems	_____
☐ Epilepsy / Seizures	☐ Rheumatic Fever	
☐ Emphysema	☐ Recent Weight Loss	☐ Jaw popping/clicking/locking
☐ Eczema	☐ Radiation Treatment	

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) _____

Medical History con't

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

   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: _____

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)*