Medical History

General health (please check): EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐

Name and address of physician _____

Physician's Phone Number _____ Last complete physical? _____

Do you smoke? _____ If yes, how much? _____

Are you taking any medication, pills or drugs? _____List medications: _____

_____

Have you ever been told by a doctor to take antibiotics before any dental treatment? Yes _____ No _____

Reason for antibiotic pre-medication_____

Do you have or have you had any of the following? If yes, please describe under remarks:

	YES	NO		YES	NO
1. Heart Disease	___	___	15. Radiation Treatment	___	___
2. High Blood Pressure	___	___	16. Liver Disease	___	___
3. Blood Disease	___	___	17. Kidney Disease	___	___
4. Rheumatic Fever	___	___	18. Hepatitis	___	___
5. Heart Murmur/Mitral Valve Prolaps (MVP)	___	___	19. Asthma Do you use an inhaler	___ ___	___ ___
6 Diabetes	___	___	20. Tuberculosis	___	___
7. Stroke	___	___	21. Allergy to:		
8. Epilepsy	___	___	Penicillin	___	___
9. Arthritis	___	___	Other Antibiotics	___	___
10. Tumor History	___	___	Local Anesthetics	___	___
11. Any Venereal Diseases	___	___	22. Are you pregnant	___	___
12 AIDS	___	___	23. Thyroid Disease	___	___
13. HIV Positive	___	___	25. Acid Reflux	___	___
14. Artificial replacements (heart valve, knees, hips)	___	___ _____	24. Have you taken steroids (cortisone) in the past two years	___	___

Medical Concerns _____

Dental History

Do you have any present dental complaints?_____

When was your last full mouth x-rays? _____

When was your last cleaning? _____

Previous Dental Care Provider _____

Have you ever been instructed in the prevention of tooth decay? _____

Have you ever been instructed in the caring for your gums? _____

If you could change anything about your smile or your teeth, what would it be? _____

_____

What would hinder your ability to achieve this goal? _____

How can we make your dental appointments more relaxing and enjoyable?_____

Additional Remarks or Comments

_____

_____

Confidential (for record and pretreatment evaluation)

Patient Information

Date _____

Patient's Name _____
Last First Middle (Preferred Name)

Address _____
Street City State Zip

Home Phone _____ Mobile Phone _____ Birth date _____ Sex _____ Marital Status _____

No. of yrs. in community _____ Work Phone _____ Ext. _____ Soc. Security # _____

Email Address _____

Previous Address (if less than 3 years) _____
Street City State Zip

Employer: _____ Occupation: _____ No. of years employed: _____

Employer address: _____

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

Family Information

Spouse's Name _____
Last First Middle

Social Security# _____Birthdate _____Work Phone _____Mobile Phone _____

Employer: _____ Occupation: _____ No. of years employed: _____

Children's Names _____

Other family members that are seen in our office: _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Mobile Phone _____

Guarantor's Information

Guarantor's Name: _____ Date of Birth _____ SS#: _____

Complete Address _____ Driver's License # _____

Home Phone _____ Work Phone _____Mobile Phone _____

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. **Payment is due at time of treatment.** I understand that even though I may have some type of insurance coverage, I am responsible for payment of services.

Dr. Valentine's office will file insurance as a courtesy. If my insurance payment is not received within 60 days, **I will make payment to Dr. Valentine** and I will be given an insurance claim form to seek reimbursement. The office will estimate what insurance will cover based on prior payments from each plan or on basic policies. Each group contract is different, and is subject to the actual policy provisions. **If your insurance does not pay what is estimated, your portion is due upon receipt of billing.** An annual interest rate of 18% will be applied per month to accounts with balance over 60 days from treatment date. If for any reason this account should be taken to small claims court, or collections, I understand that I will be responsible for all attorney & court costs. Also where appropriate, credit bureau reports may be obtained.

_____
Signature of Patient, or Responsible Party

PLEASE COMPLETE BOTH SIDES OF THIS REPORT IF NOT APPLICABLE, PUT N/A