

JAMES J. TEAGUE III, D.D.S., P.A.

PATIENT HISTORY & INFORMATION SHEETS

WELCOME! WE ARE GLAD YOU ARE HERE. WE SINCERELY APPRECIATE YOU CHOOSING OUR OFFICE FOR YOUR DENTAL CARE. OUR GOAL IS TO PROVIDE YOU WITH THE BEST DENTAL CARE POSSIBLE IN A RELAXED AND CARING ATMOSPHERE. WE ARE HERE TO SERVE YOU AND WE THANK YOU FOR THAT OPPORTUNITY.

DATE _____

NAME _____ **ADDRESS** _____

CITY _____ **STATE** _____ **ZIP** _____ **HM PHONE** _____

WORK PHONE _____ **CELL PHONE** _____ **SEX (M/F)** _____

MARITAL STATUS _____ **PATIENT BIRTHDAY** _____ **SSN#** _____

IN CASE OF EMERGENCY, NOTIFY _____

PHONE NUMBER _____

RESPONSIBLE PARTY NAME _____

ADDRESS _____

REFERRED BY _____

IF YOU HAVE DENTAL INSURANCE:

DENTAL INSURANCE Y/N _____ **EMPLOYER NAME** _____

INSURED NAME _____ **SSN** _____ **INSURED BIRTHDATE** _____

INSURANCE COMPANY NAME _____ **GROUP #** _____

INSURANCE CO. MAILING ADDRESS _____

CITY _____ **STATE** _____ **ZIP CODE** _____

SECONDARY INSURANCE? INSURED NAME _____ **INSURED DOB** _____

INSURED SSN _____ **EMPLOYER NAME** _____

GROUP NO _____ **INSURED MAILING ADDRESS** _____

DENTAL HISTORY

- 1. WHY HAVE YOU COME TO THE DENTIST TODAY? _____
- 2. APPROXIMATELY WHEN WAS YOUR LAST DENTAL VISIT? _____
- 3. DO YOU CURRENTLY HAVE ANY TEETH THAT ARE SENSITIVE OR HURTING?

- 4. ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH? _____
IF NOT, WHAT, SPECIFICALLY, WOULD YOU LIKE TO CHANGE? _____
- 5. HAVE YOU EVER WISHED YOUR TEETH WERE WHITER? HAVE YOU CONSIDERED OR TRIED BLEACHING IN THE PAST? _____
- 6. HAVE YOU SEEN DENTAL SPECIALISTS IN THE PAST? PERIODONTISTS, ENDODONTISTS OR ORTHODONTISTS? _____
- 7. ARE YOU NERVOUS OR ANXIOUS ABOUT DENTAL TREATMENT? IF SO, IS THERE ANYTHING IN PARTICULAR THAT IS MOST CONCERNING? _____
- 8. ARE THERE ANY OTHER DENTAL CONCERNS THAT YOU WOULD LIKE FOR US TO BE AWARE OF? _____

MEDICAL HISTORY

PLEASE LIST THE MEDICINES YOU ARE TAKING, INCLUDING OVER THE COUNTER MEDICINES _____

PHYSICIAN NAME AND PHONE NUMBER _____

ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO ANY MEDICINES , DENTAL ANESTHETICS, OR LATEX? PLEASE LIST _____

DO YOU SMOKE, DIP, CHEW OR USE ANY FORM OF SMOKELESS TOBACCO? _____

HAVE YOU BEEN TOLD BY A PHYSICIAN THAT YOU NEED PREMEDICATION FOR HEART PROBLEMS OR JOINT REPLACEMENT? _____

HAVE YOU EVER HAD HIP, KNEE, SHOULDER OR BACK SURGERY?

HAVE YOU HAD ANY MAJOR SURGERIES? _____

WOMEN: ARE YOU PREGNANT? _____

PLEASE CIRCLE ANY OF THE FOLLOWING THAT APPLY TO YOU:

MITRAL VALVE PROLAPSE HEART MURMUR RHEUMATIC FEVER STROKE

HEART SURGERY HEART ATTACK HIGH BLOOD PRESSURE HEMOPHILLIA

HEPATITIS HIV/AIDS DRUG/ALCOHOL ABUSE CANCER DIABETES

TUBERCULOSIS EPILEPSY SEIZURES CHEMOTHERAPY KIDNEY DISEASE

PSYCHIATRIC DISORDERS SINUS PROBLEMS

TO OUR PATIENTS WITH DENTAL INSURANCE

DENTAL INSURANCE CARRIERS SET THEIR OWN “USUAL, CUSTOMARY, AND REASONABLE” REIMBURSEMENT FEES, BASED ON MAXIMIZING THEIR PROFITS AND MINIMIZING YOUR DENTAL CARE. IN MOST CASES, THE CHARGES AT THIS OFFICE WILL EXCEED, SOMETIMES SIGNIFICANTLY, THE “UCR” FEE SCHEDULE SET BY YOUR INSURANCE COMPANY. BY SIGNING BELOW, I ACKNOWLEDGE THIS AND PERMIT MY SIGNATURE TO SERVE AS AUTHORIZATION IN FILING MY INSURANCE FOR ME AND MY DEPENDENTS. I ALSO AGREE TO HAVE PAYMENTS FROM MY INSURANCE COMPANY SENT DIRECTLY TO THIS OFFICE FOR REIMBURSEMENT OF THE ACTUAL CHARGES FOR MY DENTAL TREATMENT. I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR UNDERSTANDING MY INSURANCE COVERAGE AND THAT I PERSONALLY, NOT MY INSURANCE COMPANY, AM RESPONSIBLE FOR THE SERVICES AND CHARGES RENDERED ON MY BEHALF.

TO ALL PATIENTS

I UNDERSTAND THAT THE INFORMATION GIVEN TODAY IS CORRECT AND WILL BE HELD IN THE STRICTEST CONFIDENCE BY THIS OFFICE. PAYMENT IN FULL IS DUE AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED. WE ACCEPT CASH, PERSONAL CHECKS, MASTERCARD, VISA, DISCOVER AND CARE CREDIT.

SIGNATURE _____ DATE _____