

WELCOME: The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we care for you.



ABOUT YOU

Name: _____
 I prefer to be called: _____
 Male Female Age: _____ Birthdate: _____
 Social Security #: _____
 Drivers License #: _____
 Mailing Address: _____
 City: _____ Zip: _____
 E-Mail Address: _____
 Home Phone #: _____
 Work Phone #: _____ Ext: _____
 Where and when are the best times to reach you? _____

 Fax #: _____
 Pager #: _____
 Cell Phone #: _____
 Whom may we THANK for referring you? _____
 Other family members seen by us: _____

 Employer: _____ Occupation: _____ How long there? _____
 Employers Address: _____ City: _____ Zip: _____



SPOUSE INFORMATION

His / Her Name: _____
 Employer: _____
 Work Phone #: _____ Ext.: _____
 Social Security #: _____
 Drivers License #: _____
 Birthdate: _____



PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____
 Insurance Co. Address: _____
 City: _____
 State: _____
 Zip: _____
 Insurance Co. Phone #: _____
 Group # (Plan, Local, or Policy #) : _____
 Insured 's Name: _____
 Birthdate: _____ SS#: _____
 Relation to Insured: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____
 Home Phone #: _____
 Work Phone #: _____
 Billing Address: _____
 City, Zip: _____
 Relation: _____
 Social Security #: _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____
 Insurance Co. Address: _____
 City: _____
 State: _____
 Zip: _____
 Insurance Co. Phone #: _____
 Group # (Plan, Local, or Policy #) : _____
 Insured 's Name: _____
 Birthdate: _____ SS#: _____
 Relation to Insured: _____

I hereby authorize payment of the dental benefits otherwise payable to me directly to Grant Rickey, D.D.S.

Signature: _____ Date: _____

MEDICAL HISTORY

Physician's Name: _____

Physician's Phone #: _____

Last Visit Date: _____



In the event of an emergency, please list someone we may contact:

Name: _____

Relation: _____

Work #: _____ Ext: _____

Home #: _____

Please list any prescription or over-the-counter medications that you are currently taking:

Have you ever had any of the following diseases or medical problems?

- | | | | |
|-----|--------------------|-----|-------------------|
| Y N | Abnormal Bleeding | Y N | Hepatitis |
| Y N | Anemia | Y N | Herpes |
| Y N | Asthma | Y N | Kidney Problems |
| Y N | Colitis | Y N | Liver Disease |
| Y N | Diabetes | Y N | Seizures |
| Y N | Emphysema | Y N | Shingles |
| Y N | Epilepsy | Y N | Sinus Problems |
| Y N | Frequent Headaches | Y N | Stroke |
| Y N | Heart Surgery | Y N | Tuberculosis (TB) |

For Women:

- Y N Are you taking birth control pills?
(Antibiotics can render birth control pills ineffective.)

- Y N Are you pregnant? If "Yes", Week # _____



Please list any medical conditions that has not been asked:

Are you allergic to any of the following?

- | | | | |
|-----|--------------------|-----|--------------|
| Y N | Aspirin | Y N | Penicillin |
| Y N | Codeine | Y N | Tetracycline |
| Y N | Latex | Y N | Erythromycin |
| Y N | Dental Anesthetics | | |



Please list any drugs/materials that you are allergic to:

DENTAL HISTORY

- Y N** Has your **medical doctor** (Not Dentist) determined that you have a heart condition that requires you to take antibiotics before dental treatments?



- Y N** Has your medical doctor determined that you require an antibiotic for the care of a joint replacement or implant?

If either of the previous two questions were a "Yes" response, please list the recommended prescriptions:

Previous Dentist: _____

Last visit Date: _____

Why have you come to the dentist today?

- Y N** Are you currently in pain?

Please discuss any problems associated with dental work:

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature _____

Date _____

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have a question at any time, please ask us. We are happy to help.