

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name) Gender: _____ Family Status: _____
Social Security _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
Address: _____
Street Apartment #
City State Zip Code

Health Information

Have you ever had: (Please check all entries.)

Yes No <input type="checkbox"/> <input type="checkbox"/> AIDS or HIV Positive <input type="checkbox"/> <input type="checkbox"/> Artificial Joints or Heart Valve <input type="checkbox"/> <input type="checkbox"/> Bleeding Problems <input type="checkbox"/> <input type="checkbox"/> Diabetes <input type="checkbox"/> <input type="checkbox"/> Drug or Alcohol Addiction <input type="checkbox"/> <input type="checkbox"/> Epilepsy <input type="checkbox"/> <input type="checkbox"/> Glaucoma <input type="checkbox"/> <input type="checkbox"/> Heart Attack <input type="checkbox"/> <input type="checkbox"/> Heart Murmur <input type="checkbox"/> <input type="checkbox"/> Hepatitis <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> <input type="checkbox"/> Kidney Disease	Yes No <input type="checkbox"/> <input type="checkbox"/> Pacemaker <input type="checkbox"/> <input type="checkbox"/> Radiation or Chemotherapy <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> <input type="checkbox"/> Sickle Cell <input type="checkbox"/> <input type="checkbox"/> Stroke <input type="checkbox"/> <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> <input type="checkbox"/> Tuberculosis <input type="checkbox"/> <input type="checkbox"/> Tumors or Cancer <input type="checkbox"/> <input type="checkbox"/> Ulcers <input type="checkbox"/> <input type="checkbox"/> Aspirin Allergy <input type="checkbox"/> <input type="checkbox"/> Codeine Allergy <input type="checkbox"/> <input type="checkbox"/> Darvon Allergy <input type="checkbox"/> <input type="checkbox"/> Erythromycin Allergy	Yes No <input type="checkbox"/> <input type="checkbox"/> Ibuprofen Allergy <input type="checkbox"/> <input type="checkbox"/> Latex Allergy <input type="checkbox"/> <input type="checkbox"/> Local Anesthetic Allergy <input type="checkbox"/> <input type="checkbox"/> Nickel Allergy <input type="checkbox"/> <input type="checkbox"/> Nitrous Oxide Allergy <input type="checkbox"/> <input type="checkbox"/> Penicillin Allergy <input type="checkbox"/> <input type="checkbox"/> Percodan Allergy <input type="checkbox"/> <input type="checkbox"/> Sleeping Pill Allergy <input type="checkbox"/> <input type="checkbox"/> Sulfa Allergy <input type="checkbox"/> <input type="checkbox"/> Tetracycline Allergy <input type="checkbox"/> <input type="checkbox"/> Valium Allergy <input type="checkbox"/> <input type="checkbox"/> Asthma OTHER: <input type="checkbox"/> _____	Current Medications: _____ _____ _____ _____ _____
---	--	--	--

- Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____
- Are you now under the care of a physician? Yes No
If yes, please explain: _____
- Name of Physician: _____ Kaiser #: _____ Phone: _____
- Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

Women Only:

Are you pregnant now? _____ Do you anticipate becoming pregnant? _____

Are you taking birth control pills? _____

I understand that taking antibiotics may cause birth control pills to fail. This could result in pregnancy. It is my responsibility to use additional methods of birth control and consult my physician should antibiotics be prescribed for dental treatment. _____

Initial (women only)

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian

Signature of Doctor

Date

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #
City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____
Last First MI

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: «PIns Name»

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____
Last First MI

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: «SIns Name»

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. A patient's insurance plan is a contract between the subscriber, employer and the insurance company. Dr. Tinney's staff will bill this insurance as a courtesy to the patient. However any balances incurred are the sole responsibility of the patient's responsible party.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I authorize the release of my medical and /or dental records to appropriate insurance carriers and to physicians or dental specialists as deemed necessary and proper by Dr. Tinney. I have received a copy of Dr. Tinney's Dental Materials Fact Sheet and the Notice of Privacy Policy.

I grant permission to Doctor and Staff to take the necessary x-rays, administer local anesthetics, medications and any appropriate procedures as are necessary or advisable for examination, diagnosis and treatment of the patient of record.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian _____ Date: _____ Relationship to Patient: _____