HEALTH HISTORY & REGISTRATION

DATE ______________________

PATIENT'S NAME ______________________ PATIENT# ______________

HOME ADDRESS ______________________ CITY ______________ ST ________ ZIP ____________

HOME PHONE ______________ WORK PHONE ______________ BIRTHDAY __________ SOCIAL SEC# ______________

CIRCLE ONE: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

YOUR OR YOUR PARENT'S EMPLOYER ______________________ OCCUPATION ______________

BUSINESS ADDRESS ______________________ CITY ______________ ST ________ ZIP ____________

HOW LONG EMPLOYED ______________________ EMPLOYED'S SOCIAL SEC# ______________

SPOUSE'S NAME ______________________ EMPLOYER ______________

WORK PHONE ______________________ SPOUSE'S SOCIAL SEC# ______________

NAME OF PERSON RESPONSIBLE FOR ACCOUNT ______________________ RELATIONSHIP ______________

ADDRESS ______________________ CITY ______________ ST ________ ZIP ____________

PHONE ______________

REFERRED BY ______________ PREVIOUS DENTIST ______________ PHONE ______________

EMERGENCY CONTACT ______________ RELATIONSHIP ______________ PHONE ______________

NAME OF INSURED ______________________ RELATIONSHIP TO PATIENT ______________

INSURANCE COMPANY ______________________ GROUP# ______________ ID# ______________

INSURANCE COMPANY ADDRESS ______________________ CITY ______________ ST ________ ZIP ____________

DO YOU HAVE DOUBLE COVERAGE? ☐ YES ☐ NO IF YES, INSURANCE COMPANY'S NAME ______________

MEDICAL HISTORY

	YES	NO		YES	NO
Heart Failure	___	___	Hemophilia	___	___
Heart Disease or Attack	___	___	Fever Blisters	___	___
Angina Pectoris	___	___	Epilepsy or Seizures	___	___
High Blood Pressure	___	___	Fainting or Dizzy Spells	___	___
Heart Murmur	___	___	Nervousness	___	___
Rheumatic Fever	___	___	Psychiatric Treatment	___	___
Congenital Heart Lesions	___	___	Sickle Cell Disease	___	___
Scarlet Fever	___	___	Glaucoma	___	___
Artificial Heart Valve	___	___	Chemotherapy (Cancer, Leukemia)	___	___
Heart Pacemaker	___	___	Venereal Disease (Syphilis, Gonorrhea, etc.)	___	___
Heart Surgery	___	___	Bruise Easily	___	___
Artificial Joints (Hip, Knee)	___	___	Emphysema	___	___
Anemia	___	___	Tuberculosis (TB)	___	___
Stroke	___	___	Asthma	___	___
Kidney Trouble	___	___	Hay Fever	___	___
Ulcers	___	___	Sinus Trouble	___	___
Cosmetic Surgery	___	___	Allergies or Hives	___	___
A.I.D.S.	___	___	Diabetes	___	___
Hepatitis A (infectious)	___	___	Thyroid Disease	___	___
Hepatitis B (serum)	___	___	X-ray or Cobalt Treatment	___	___
Liver Disease	___	___	Arthritis	___	___
Yellow Jaundice	___	___	Rheumatism	___	___
Blood Transfusion	___	___	Cortisone Medicine	___	___
Drug Addiction	___	___	Pain in Jaw Joints	___	___

Are you allergic or have you reacted adversely to any of the following medications?

MEDICATION	YES	NO
Aspirin	___	___
Darvon	___	___
Nitrous Oxide	___	___
Percodan	___	___
Local Anesthetic	___	___
Codeine	___	___
Erythromycin	___	___
Valium	___	___
Penicillin	___	___

	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	___	___
Are you under a PHYSICIAN'S CARE now?	___	___
For What?		
Are you currently taking any medication?	___	___

If yes, what? ______________________

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REASON FOR THIS DENTAL VISIT:

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CONSENT:
The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance charge of 1.50% per month (18% annual rate) will be added to any overdue balance after 60 days. I also assign all insurance benefits to the Doctor.

PATIENT Signature (Parent of Child) ______________ Date: __________ DENTIST Signature ______________

Gary D. Davis D.D.S, P.C.

Notice of Privacy Practices

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a patient's rights section describing your rights under the law. You have the right to review this section before signing this form. The terms of our notice may change. If we change our notice, you may retain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- We have a notice of Privacy Practices and the patient has the opportunity to review this notice.
- We reserve the right to change the Notice of Privacy Practices.
- He/She has the right to restrict the uses of their information, but we do not have to agree to those restrictions.

Payment Agreement

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for the payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance charge of 1.50% per month (18% annual rate) will be added to any overdue balances after 60 days. I also assign all insurance benefits to the Doctor. In the event that my account is turned over to collections, I will be responsible for court costs, attorney fees, collection costs, and any other fees for monies owed.

______________________________ Patient or Responsible Party

____________ Date