



ANDY HOLLIFIELD D.M.D., P.A.

Family Dentistry

WELCOME

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

1

ABOUT YOU

Today's Date: _____

E-Mail Address: _____

Name: _____
Mr. Mrs. Ms. Dr. Last First MI

I prefer to be called: _____ Male Female

Birthdate: ____/____/____ Age: ____ SS#: _____

Home Address: _____

City State Zip
 Single Married Divorced Widowed Separated

Hm #:(____) Cell # _____

Wk #:(____) Ext: ____ DL #/State: _____

When & where are best times to reach you? _____

Preferred method of contact: Text Message Email Phone Call

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Whom may we THANK for referring you? _____

Other family members seen by us: _____

Previous / Present / Dentist: _____
(Please Circle)

Last Visit Date: _____

2

SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Wk #:(____) Ext: ____ SS #: _____

Birthdate: ____/____/____ DL#/State: _____

Person Responsible for Account: _____

Wk #:(____) Ext: ____ Hm #:(____) _____

Cell #:(____) _____

Billing Address: _____

Relationship: _____ SS #: _____

Employer: _____ DL #/State: _____

3

INSURANCE

Primary Insurance

Dental Coverage: Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #:(____) _____

Group # (Plan or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID#: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Insurance

Dental Coverage: Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #:(____) _____

Group # (Plan or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID#: _____

Insured's Employer: _____

Employer's Address: _____

In Event of Emergency

His / Her Name: _____ Relation: _____

Wk #:(____) Hm #:(____) _____

Cell # (____) _____

Address: _____

City State Zip

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MEDICAL HISTORY

Today's Date: _____

Do you have a personal physician? Yes No

Physician's Name: _____

Phone #:(____) Date of last visit: _____

Are you currently under the care of a physician? Yes No

Please explain: _____

4 MEDICAL HISTORY CONTINUED

Your current physical health is: Good Fair Poor

Do you smoke or use tobacco in any other form? Yes No

Have you had any metal rods, pins or implants? Yes No

Are you taking any prescriptions / over-the-counter or herbal supplement drugs: Yes No

Please list each one: _____

Have you ever taken Phen-Fen? (Also know as Redux or Pandimin) Yes No

If so, when? _____

Have you ever taken Bisphosphonates: Yes No

(Ex. Boniva, Fosamax, Actonel, Zometa, Aredia)

If so, when? _____

For Women: Are you using a prescribed method of birth control?

Are you pregnant? Yes No Week #: _____ Yes No

Are you nursing? Yes No Hospitalized for any reason Yes No

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

- | | |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes/Fever Blisters |
| <input type="checkbox"/> Y <input type="checkbox"/> N Alcohol/Drug Abuse | <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N HIV+ / AIDS |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones/Joints/Valves | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion | <input type="checkbox"/> Y <input type="checkbox"/> N Lupus |
| <input type="checkbox"/> Y <input type="checkbox"/> N Colitis | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Seizures |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Frequent Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease/Traits |
| <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB) |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcers |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N Cancer/Chemotherapy |
| | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation to Head or Neck |

Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin | <input type="checkbox"/> Y <input type="checkbox"/> N Erythramycin | <input type="checkbox"/> Y <input type="checkbox"/> N Sulfa |
| <input type="checkbox"/> Y <input type="checkbox"/> N Codeine | <input type="checkbox"/> Y <input type="checkbox"/> N Latex | <input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin | <input type="checkbox"/> Y <input type="checkbox"/> N Other |

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

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA. We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between the patient and provider. Thank you for choosing us to serve your dental needs!

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials _____ Date _____

Doctor's Comments: _____

MEDICAL HISTORY UPDATE

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____ Signature _____ Date _____

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____ Signature _____ Date _____

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____ Signature _____ Date _____

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____ Signature _____ Date _____

5 DENTAL HISTORY

Reason for today's visit: Emergency Consultation New Patient

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had a serious/difficult problem associated with any previous dental work? Yes No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ / TMD)? Yes No

Are you happy with your smile? Y N

If no, please explain _____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge, and understand it is my responsibility to inform this office of any future changes to my medical status.

Signature _____ Date _____

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Our policy requires payment in full for all services rendered at the time of each visit, unless prior financial arrangements have been made with the office staff. I also understand that I am financially responsible for any co-payments or deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office (Andy Hollifield, DMD, PA) of the group insurance benefits. I understand that I am ultimately responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.

Signature _____ Date _____

Authorized for payment: If my check is returned or dishonored for any reason, I authorize Andy Hollifield, D.M.D., P.A. to initiate an electronic debit entry to my checking account for the face amount of my check, and an additional returned check fee debit entry of \$30 (or legal limit), plus any applicable sales tax. This authorization applies to any dishonored check made payable to Andy Hollifield, D.M.D., P.A. and shall remain in full force until Andy Hollifield, D.M.D., P.A. receives written notification from me, with a reasonable time to act.

Signature: _____