DR. RONALD E. TERRY FAMILY DENTISTRY

WELCOME TO OUR DENTAL PRACTICE

Please take a few minutes to answer the following questions so we can better assist you with achieving the best smile possible! *Please print.*

PATIENT INFORMATION

DATE: _____ *Name:* _____ _____ _____ *BIRTHDATE:* _____
Last Name *First Name* *MI*

Address: _____ *Telephone#* _____ _____
Street Address *Home#* *Cell#*

City _____ *State* _____ *Zip Code* _____ *Email* _____

Sex ___ *M* ___ *F* *Minor* ___ *Single* ___ *Married*___ *Divorced* ___ *Widowed* ___ *SSN* _____

Employer _____ *Telephone #* _____
Name of Business *Work Phone #*

Employer Address _____
Street Address *City* *State* *Zip Code*

Who should we thank for referring you? _____
Full Name *Telephone*

_____
Street Address *City* *State* *Zip Code*

In Case of Emergency, who should we contact? _____
Name *Telephone* *Relationship*

Who Is responsible for this Account Balance: _____ Relationship to patient: _____

DENTAL INSURANCE Subscriber Information

Primary Insured/Subscriber: _____ _____ _____
Last Name *First Name* *Initial*

Birth date _____ *SSN* _____ *Relationship to Patient* _____

Telephone # _____ _____ _____
Home # *Cell #* *Work #*

Address: _____ _____ _____ _____
Home Street Address *City* *State* *Zip Code*

Subscriber Employed by _____
Business Name *Business Address*

Dental Insurance Co. _____ *Telephone #* _____

Please tell us what brings you to us today? _____
What concerns you most about your teeth? _____

Please complete health history on reverse side, Thank you!

DR. RONALD E. TERRY *FAMILY DENTISTRY*

DENTAL HISTORY

Date of Last dental visit: _____ Date of Last Dental X-Rays _____ How often do you Brush/Floss? _____
Have you ever had any type of reaction to dental treatment or anesthetics ____Yes ____ No
Please check all conditions that you want Dr. Terry to check out:

___ Bad Breath __ Bleeding Gums __ Blisters on lips/mouth __Grinding Teeth __Loose Teeth/Fillings __Tooth Pain
___Sensitivity to Cold ___Sensitivity to Heat ___Sensitivity to Sweets ___Frequent Headaches ___ Other

MEDICAL HISTORY

You Physician's Name _____ Address _____ Telephone _____

Are you currently under the care of this Physician? _____

Do you have any serious illnesses? _____
Please describe

What medications do you currently take? _____
Please list all medications, add a separate sheet if necessary

Do You Smoke? _____
Do You Drink alcohol? _____
Do You use other drugs? _____
Are you Pregnant? _____

Have you ever had any allergic reaction to any medicine or dental procedure?
_____
_____
please describe and list all allergies

Please check all that apply:

___*AIDS/HIV Positive*
___*Anemia*
___*Arthritis*
___*Artificial Heart Valve*
___*Artificial Joints*
___*Asthma/Shortness of breath*
___*Abnormal bleeding with extractions/surgery*
___*Blood Disease*
___*Cancer*
___*Chemical Dependency*
___*Chemotherapy*
___*Chronic Fatigue Syndrome*
___*Circulatory Problems*
___*Congenital Heart Problems*
___*Cough, Persistent or bloody*
___*Diabetes*
___*Emphysema*
___*Epilepsy*
___*Emphysema*
___*Fainting or Dizziness*
___*Glaucoma*

___*Headaches*
___*Heart Murmur*
___*Heart Problems/Mitral Valve Prolaspe*
___*Hepatitis-Type*
___*Herpes*
___*High/Low Blood Pressure*
___*Jaundice*
___*Jaw Pain*
___*Latex Sensitivity*
___*Kidney Disease*
___*Nervous Problems*
___*Pacemaker*
___*Psychiatric Care*
___*Radiation Treatment*
___*Respiratory Disease*
___*Rheumatic/Scarlet Fever*
___*Sinus Trouble*
___*Thyroid Problems*
___*Tonsillitis*
___*Tuberculosis*
___*Tonsillitis*
___*Venereal Disease*

Is there anything else we should know about your medical health?
_____

I Authorize Dr. Terry to release information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I agree to and will pay for services rendered to me or my dependent child.

Signed: _____Date: _____ Relationship to Patient _____

Thank You for Choosing Us for Your Dental Care. We Make It Easy To Smile!