

SELECT YOUR DENTIST:

Dr. Will Turner

Dr. Jason Butler

DATE: _____

Dr. Melissa Owen

PATIENT INFORMATION:

Name _____
(LAST) (FIRST) (MIDDLE INITIAL)

Married Single

Male Female

DOB _____

Address: _____, State _____ Zip _____

What name would you like to be called in this office? _____

Whom may we thank for referring you? _____

School/College: _____ City _____ State _____ Full Time Part Time

FAMILY INFORMATION:

MOTHER

FATHER

Name: _____

Name: _____

Address: _____

Address: _____

City _____ State _____ Zip _____

City _____ State _____ Zip _____

Home# _____ Work _____ Ext _____

Home# _____ Work _____ Ext _____

Cell # _____ Pager _____

Cell # _____ Pager _____

Email: _____

Email: _____

Birthdate: _____ SSN#: _____

Birthdate: _____ SSN#: _____

Employer/Occupation: _____

Employer/Occupation: _____

Please name two people to contact outside of immediate family in case of emergency: (not living with you)

Name: _____

Home# _____ Work# _____

Address: _____

City: _____ State: _____ Zip: _____

Name: _____

Home# _____ Work# _____

Address: _____

City: _____ State: _____ Zip: _____

FINANCIAL INFORMATION: (note: please review our Financial Policy form)

Please check the person financially responsible for the account

Patient Father Mother Guardian Spouse Other (specify) _____

Does responsible party have an account with this office Yes No

Method of Payment: Check Cash Mastercard/Visa

Where appropriate and necessary, credit bureau reports will be obtained.

Dental Insurance 1

Dental Insurance 2

Employee Name: _____

Employee Name: _____

Employer Name: _____

Employer Name: _____

Insurance Co. Name: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Address: _____

Subscriber I.D. #: _____

Subscriber I.D. #: _____

Group #: _____

Group #: _____

Employee Date of Birth: _____

Employee Date of Birth: _____

Authorization: I hereby authorize payment directly to Drs. Turner & Butler, DMD, PA and the associate dentist, of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

Responsible Party Signature: _____

Date: _____

State Driver's License #: _____

Please complete the following page regarding Medical History

CHILD MEDICAL HISTORY FORM pg2

Patient Name: _____ **Birth Date:** _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain _____
 Have you ever been hospitalized or had a major operation? Yes No If yes, please explain _____
 Have you ever had a serious head or neck injury? Yes No If yes, please explain _____
 Are you taking any medications? (Rx, OTC, Supplements) Yes No If yes, please list all here _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes, please explain _____
 Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes, please explain _____
 Are you on a special diet? Yes No If yes, please explain _____
 Do you use tobacco? Yes No
 Do you use controlled substances? Yes No
 Do you have sleep apnea? Yes No
 Do you use a C-PAP machine? Yes No
 Do you use Electronic cigarette? Yes No

Women are you
 Pregnant or Trying to get pregnant?
 Nursing?
 Taking oral contraceptives

Are you allergic to any of the following?
 Aspirin Penicillin Codeine Acrylic Metal Latex Sulfa Drugs Local Anesthetics
 Other If yes, please explain: _____

Do you have, or have you had, any of the following?

<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Shingles
<input type="checkbox"/> Anemia	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Angina	<input type="checkbox"/> Cortisone Medication	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Pace Maker	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Drug/Alcohol Addiction	<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Organ Transplant	<input type="checkbox"/> Stomach/Intestinal
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Easily Winded	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthmas	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Pain in Joints	<input type="checkbox"/> Swelling of Limbs
<input type="checkbox"/> Blood Clot/DVT	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Herpes	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Breathing Problems	<input type="checkbox"/> Fainting Spells/Dizziness	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Hives or Rash	<input type="checkbox"/> Renal Dialysis	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Irregular Heartbeat		

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

I understand that Croasdaile Dental Arts (Drs. Turner & Butler, DMD, PA) and their associate dentist requires that a new Medical History Form be completed once a year.

Signature of Patient, Parent or Guardian _____ **Date:** _____