Patient Information (Please PRINT clearly. Thank you.)

First name: _____ Last name: _____ Middle Initial: _____

Preferred name: _____ Birth Date: _____ Age: _____

Social Security #: _____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Address: _____

City, State, Zip: _____

Please Provide as much information as possible for appointment confirmation purposes

Home phone :(___) ____-_____Work phone: (____) ____-_____Cell: (___) ____-_____

Email address: _____

WHAT IS YOUR PREFERRED CONTACT METHOD? _____

WOULD YOU LIKE TO OPT-IN FOR TEXT MESSAGE REMINDERS? ☐ YES ☐ NO

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired Student Status: ☐ Full Time ☐ Part Time

Employer: _____ City, State: _____

EMERGENCY CONTACT _____ Phone: (___) ____-_____

How did you find our office? (Referral Source)_____

Responsible Party (if someone other than patient)

First name: _____ Last name: _____ Middle Initial: ____

Address: _____

Home phone :(___) ____-_____Work phone: (____) ____-_____Cell: (___) ____-_____

Birth Date: _____ Soc. Sec: _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other

Insurance Information (Please provide insurance card)

Insurance Company: _____ Employer/ Group name:_____

Subscriber name: _____ Subscriber Birth Date: _____

Subscriber ID# or Social Security #:_____

Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other

Medical History

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.

Physician's Name: _____ City/State: _____Office Phone: _____

1. Are you currently undergoing medical treatment?	Y	N
If so, please explain: _____		
2. Are you currently taking any medications (including OTC)?	Y	N
If you need more room, please use the back of this page.		
If so, please explain: _____		
3. Any changes to your health in the past year?	Y	N
If so, please explain: _____		
4. Have you had major surgery or been hospitalized in the last 5 years?	Y	N
If so, please explain: _____		

PATIENT NAME _____ Birth Date _____

Do you use tobacco? O Yes O No Do you use controlled substances? O Yes O No

Women: Are you:
Pregnant/Trying to get pregnant? O Yes O No Taking Oral Contraceptives? O Yes O No Nursing? O Yes O No

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

Preferred Pharmacy: _____ Address: _____ Phone: _____
Physicians Name: _____ City/State: _____ Phone: _____
When were your last dental exam and x-rays taken? _____
Main Dental concern: _____
Do you use a pre-medication prior to dental treatment (Anti-biotic)? O Yes O No

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

AIDS/HIV Positive	O Yes O No	Excessive Thirst	O Yes O No	Mitral Valve Prolapse	O Yes O No
Alzheimer's Disease	O Yes O No	Fainting Spells/Dizziness	O Yes O No	Pain in Joints	O Yes O No
Anaphylaxis	O Yes O No	Frequent Cough	O Yes O No	Parathyroid Disease	O Yes O No
Anemia	O Yes O No	Frequent Diarrhea	O Yes O No	Psychiatric Care	O Yes O No
Angina	O Yes O No	Frequent Headaches	O Yes O No	Radiation Treatments	O Yes O No
Arthritis/Gout	O Yes O No	Genital Herpes	O Yes O No	Recent Weight Loss	O Yes O No
Artificial Heart Valve	O Yes O No	Glaucoma	O Yes O No	Renal Dialysis	O Yes O No
Artificial Joint	O Yes O No	Hay Fever	O Yes O No	Rheumatic Fever	O Yes O No
Asthma	O Yes O No	Heart Attack/Failure	O Yes O No	Scarlet Fever	O Yes O No
Blood Disease	O Yes O No	Heart Beat Fluctuations	O Yes O No	Shingles	O Yes O No
Blood Transfusion	O Yes O No	Heart Murmur	O Yes O No	Sickle Cell Disease	O Yes O No
Breathing Problem	O Yes O No	Heart Pace Maker	O Yes O No	Sinus Trouble	O Yes O No
Bruise Easily	O Yes O No	Heart Trouble/Disease	O Yes O No	Spina Bifida	O Yes O No
Cancer	O Yes O No	Hemophilia	O Yes O No	Stomach/Intestinal Disease	O Yes O No
Chemotherapy	O Yes O No	Hepatitis A	O Yes O No	Stroke	O Yes O No
Chest Pains	O Yes O No	Hepatitis B or C	O Yes O No	Swelling of Limbs	O Yes O No
Cold Sores/Fever Blisters	O Yes O No	Herpes	O Yes O No	Thyroid Disease	O Yes O No
Congenital Heart Disorder	O Yes O No	High Blood Pressure	O Yes O No	Tonsillitis	O Yes O No
Convulsions	O Yes O No	Hives or Rash	O Yes O No	Tuberculosis	O Yes O No
Cortisone Medicine	O Yes O No	Hypoglycemia	O Yes O No	Tumors or Growths	O Yes O No
Diabetes	O Yes O No	Irregular Heartbeat	O Yes O No	Ulcers	O Yes O No
Drug Addiction	O Yes O No	Kidney Problems	O Yes O No	Venereal Disease	O Yes O No
Easily Winded	O Yes O No	Leukemia	O Yes O No	Yellow Jaundice	O Yes O No
Emphysema	O Yes O No	Liver Disease	O Yes O No		
Epilepsy or Seizures	O Yes O No	Low Blood Pressure	O Yes O No		
Excessive Bleeding	O Yes O No	Lung Disease	O Yes O No		

Have you ever had any serious illness not listed above? O Yes O 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.

*****SIGNATURE OF PATIENT, PARENT, or GUARDIAN** _____ **DATE** _____

PATIENT POLICY AND AGREEMENT

Assignment of Benefits

I hereby authorize payment of dental benefits to **BRIAN R. GLOVER DDS** for the services completed.

I give my permission to the doctor to submit insurance benefit claim forms in my name and on the behalf of myself, my spouse and/or my minor children.

I realize that I am responsible for and agree to pay any charges not covered by my insurance. This includes unmet deductibles, non-covered services, etc.

Co-pays and cash plans are due at the time of service.

Special arrangements can be made, but must be mutually agreed to **IN ADVANCE**. Please contact the staff at any time if you have any difficulties. We will do everything possible to find a way to provide the dental care services you need.

Scheduling Appointments and Cancellation Policy

It is requested that you will arrive promptly for each appointment scheduled. If you are unable to keep an appointment please give our office **48 hours** notice. If you do not call to cancel your appointment or do not show up for your scheduled appointment, you will be charged $30. We provide an answering machine during non-business hours to serve you better in keeping and rescheduling appointments.

Despite careful scheduling, emergencies can cause delays. We try our very best to stay on time. If your appointment time is affected due to an unforeseen emergency, we'll try to notify you. We know that your time is valuable, too. You will receive the same quality dental care no matter how our schedule is running.

I HAVE READ, UNDERSTAND, AND AGREE TO THE STATEMENTS OUTLINED ABOVE.

_____ _____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE

Dr Brian R. Glover
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