

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

PATIENT NAME _____ Birth Date _____

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

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

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

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.

***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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