DATE_____

NAME_____ ( ) Married ( ) Single ( ) Male ( ) Female

ADDRESS _____

CITY _____ STATE _____ ZIP _____

BIRTHDATE_____/_____/_____ EMAIL ADDRESS _____

HOME _____ CELL _____ WORK_____

PLACE OF EMPLOYMENT _____SS#_____

IF FULL TIME STUDENT: SCHOOL NAME _____

SPOUSE'S NAME _____CONTACT # _____

PERSON RESPONSIBLE – ***please check one:*** ( )PATIENT ( )GUARDIAN ( )SPOUSE ( )FATHER ( )MOTHER

NAME _____SS#_____

ADDRESS _____CITY_____STATE_____ZIP_____

BIRTHDATE ____/_____/_____ CONTACT NUMBER_____

PRIMARY INSURANCE INFORMATION

INSURANCE CO. NAME_____EFFECTIVE DATE_____

ADDRESS_____CITY_____STATE_____ZIP_____

INSURED NAME_____RELATIONSHIP TO PATIENT_____

INSURED SEX _____DATE OF BIRTH _____SS# _____

INSURED EMPLOYER _____PHONE_____

INSURED ADDRESS _____CITY_____STATE_____ ZIP_____

ID NO. _____ GROUP NO. _____PLAN NO_____

FULL TIME_____ PART TIME _____ RETIRED _____

SECONDARY INSURANCE INFORMATION

INSURANCE CO. NAME_____EFFECTIVE DATE_____

ADDRESS_____CITY_____STATE_____ZIP_____

INSURED NAME_____RELATIONSHIP TO PATIENT_____

INSURED SEX _____DATE OF BIRTH _____SS# _____

INSURED EMPLOYER _____PHONE_____

INSURED ADDRESS _____CITY_____STATE_____ ZIP_____

ID NO. _____ GROUP NO. _____PLAN NO_____

FULL TIME_____ PART TIME _____ RETIRED _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY

NAME _____CONTACT NUMBER_____

HAS ANY MEMBER OF YOUR FAMILY EVER BEEN TREATED IN OUR OFFICE? ( ) YES ( ) NO

WHOM MAY WE THANK FOR REERRING YOU TO OUR OFFICE? _____

AUTHORIZATION

I understand that I am responsible for all costs of dental treatment. I understand, I will be charged late fees at the rate of 1/5% per month, for any unpaid balance still owing 30 days after the date of service. I further agree to be responsible for any costs of collection, including but not limited to collection agency fees, court costs and reasonable attorney's fees. I hereby authorize Clark A. Downey, DDS to administer such medication and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

X_____

PATIENT OR RESPONSIBLE PARTY

_____ _____

DATE STATE DRIVER'S LICENSE #

STILL WATERS FAMILY DENTISTRY

MEDICAL HISTORY

PATIENT NAME _____ ***BIRTHDATE*** _____

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 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 medication, pills, or drugs? ( )YES ( )NO *If yes, please explain:* _____
_____
_____

Do you take, or have you taken Phen-Fen or Redux? ( )YES ( )NO
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?( )YES( )NO

Are you on a special diet? ( )YES ( )NO

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 following?

( )ASPIRIN ( )PENICILLIN ( )CODEINE ( )LOCAL ANESTHETICS ( )ACRYLIC ( )METAL ( )LATEX ( )SULFA DRUGS

( )OTHER *If yes, please explain:* _____

Do you have, or have you had any of the following? ***Please check or circle the ones that apply to you.***

AIDS/HIV POSITIVE	BREATHING PROBLEM	EASILY WINDED	HAY FEVER	HIVES OR RASH	PARATHYROID DISEASE	SPINA BIFIDA
ALZHEIMER'S DISEASE	BRUISE EASILY	EMPHYSEMA	HEART ATTACK/FAILURE	HYPOGLYCEMIA	PSYCHIATRIC CARE	STOMACH/INSTESTINAL DISEASE
ANAPHYLAXIS	CANCER	EPILEPSY/SEIZURES	HEART MURMUR	IRREGULAR HEARTBEAT	RADIATION TREATMENTS	STROKE
ANEMIA	CHEMOTHERAPY	EXCESSIVE BLEEDING	HEART PACEMAKER	KIDNEY PROBLEMS	RECENT WEIGHT LOSS	SWELLING OF LIMBS
ANGINA	CHEST PAINS	EXCESSIVE THIRST	HEART TROUBLE/DISEASE	LEUKEMIA	RENAL DIALYSIS	THYROID DISEASE
ARTHRITIS/GOUT	COLD SORES/FEVER BLISTERS	FAINTING SPELLS/DIZZINESS	HEMOPHILLA	LIVER DISEASE	RHEUMATIC FEVER	TONSILITIS
ARTIFICIAL HEART VALVE	CONGENTIAL HEART DISORDER	FREQUENT COUGH	HEPATITIS A	LOW BLOOD PRESSURE	RHEUMATISM	TUBERCULOSIS
ARTIFICIAL JOINT	CONVULSIONS	FREQUENT DIARRHEA	HEPATITIS B OR C	LUNG DISEASE	SCARLET FEVER	TUMORS OR GROWTHS
ASTHMA	CORTISONE MEDICINE	FREQUENT HEADACHES	HERPES	MITRAL VALVE PROLAPSE	SHINGLES	ULCERS
BLOOD DISEASE	DIABETES	GENITAL HERPES	HIGH BLOOD PRESSURE	OSTEOPOROSIS	SICKLE CELL DISEASE	VENEREAL DISEASE
BLOOD TRANSFUSION	DRUG ADDICTION	GLAUCOMA	HIGH CHOLESTEROL	PAIN IN JAW JOINTS	SINUS TROUBLE	YELLOW JAUNDICE

Have you ever had any serious illness not listed above?

_____
_____

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*** _____

Still Waters Family Dentistry, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICY OF PRIVACY PRACTICE

You may refuse to sign this acknowledgement

I, _____ , have received a copy of this office's Notice of
Print Name

Privacy Practices.

_____
Signature

_____
Date

I give the following people permission to discuss my dental information with Ossian Dental.

_____
Name/Relationship

_____
Name/Relationship

_____
Name/Relationship

_____
Signature

_____
Date