Southlake Dental Care

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PATIENT INFORMATION

DATE________________

Name ____ Preferred Name _______________ Age ___ Sex ___ Single/Married
Last First I.

Date of Birth ________________ Social Security No.____________________ Drivers License ________________

Home Address ________________________________ City ________________ State _____ Zip Code __________

Home Phone ____________________ Work Phone ____________________ Cell Phone ____________________

Employer ____ Email Address ________________________________

Spouses Name ____________________ Work Phone ________________ Employer __________________________

Children's Names ____

Whom may we thank for referring you to this office? ____

EMERGENCY CONTACT ____

INSURANCE INFORMATION

Primary Dental Insurance ____________________________ Name of Insured ________________________
Contract No. ____________________ Group No.__________ Insured DOB __________ Insured SS# __________

Secondary Dental Insurance ____________________________ Name of Insured ________________________
Contract No. ____________________ Group No.__________ Insured DOB __________ Insured SS# __________

ASSIGNMENT OF BENEFITS & TERMS OF PAYMENT

I authorize the release of any medical information necessary to process a claim on any insurance policy. I hearby assign to and authorize payments to Drs. Deep & Daughtry, P.C. of all benefits payable under such insurance policy. This information is given for the purpose of establishing an account and medical file with Drs. Deep, Daughtry & Gonzalez. It is understood that I will be responsible for all present and future services. **I DO UNDERSTAND THAT REGARDLESS OF THE INSURANCE COVERAGE THAT I HAVE, I AM RESPONSIBLE FOR PAYING ALL CHARGES.** In the event of non-payment of charges for dental services rendered, I agree to pay all costs of collection, including a reasonable attorney's fee, and further waive all rights of exemption as to personal property under the Constitution and Laws of the State of Alabama. I have read this agreement and do understand its provisions.

PATIENT SIGNATURE ____ DATE ____________________

PARENTAL CONSENT FOR A MINOR

I hereby authorized that all necessary dental services and methods be rendered for ________________________________

Date ____________ Signature ______________________________ Relationship ________________________

MEDICAL HEALTH HISTORY

PATIENT NAME: ______________________________ DATE: ____________

PATIENT MEDICAL HISTORY

PHYSICIAN ______________ OFFICE PHONE ______________ DATE OF LAST EXAM ______________

	YES	NO
Do you use tobacco?	❑	❑
Do you use alcohol?	❑	❑
How much? ____________		
Have you used any illicit drugs?	❑	❑
What Substance? ____________		
How recently? ____________		
Do you wear contact lenses?	❑	❑

Allergies

YES	NO		YES	NO	
❑	❑	Barbiturates	❑	❑	Penicilin
❑	❑	Aspirin	❑	❑	Other Antibiotics
❑	❑	Sedatives	❑	❑	Local Anesthetics
❑	❑	Iodine	❑	❑	Sulfa Drugs
❑	❑	Latex	❑	❑	Other ________

	YES	NO
Are you under medical treatment now?	❑	❑
Explain ____________		
Have you had any surgeries or hospitalization in the past 5 years?	❑	❑
Explain ____________		

For women only	YES	NO
Are you or might you be pregnant?	❑	❑
Are you nursing?	❑	❑
Are you taking birth control pills?	❑	❑

Medications

List any medications you are currently taking including any over-the-counter medications and herbals:

____________ ____________

____________ ____________

____________ ____________

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

	YES	NO		YES	NO		YES	NO
High Blood Pressure	❑	❑	Heart Disease	❑	❑	Chest Pains	❑	❑
Heart Attack	❑	❑	Cardiac Pacemaker	❑	❑	Easily Winded	❑	❑
Rheumatic Fever	❑	❑	Heart Murmur	❑	❑	Stroke	❑	❑
Swollen Ankles	❑	❑	Angina	❑	❑	Hay Fever/Allergies	❑	❑
Fainting/Seizures	❑	❑	Frequently Tired	❑	❑	Tuberculosis	❑	❑
Asthma	❑	❑	Anemia	❑	❑	Radiation Therapy	❑	❑
Low Blood Pressure	❑	❑	Emphysema	❑	❑	Glaucoma	❑	❑
Epilepsy/Convulsions	❑	❑	Cancer	❑	❑	Recent Weight Loss	❑	❑
Leukemia	❑	❑	Arthritis	❑	❑	Liver Disease	❑	❑
Diabetes	❑	❑	Joint Replacement or Implant	❑	❑	Heart Trouble	❑	❑
Kidney Diseases	❑	❑	Hepatitis/Jaundice	❑	❑	Respiratory Problems	❑	❑
AIDS or HIV Infection	❑	❑	Sexually Transmitted Disease	❑	❑	Other ________	❑	❑
Thyroid Problem	❑	❑	Stomach Troubles/Ulcers	❑	❑			

COMMENTS ____

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I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand tha providing incorrect information can be dangerous to my health.

SIGNATURE

X ____

PATIENT, PARENT OR GUARDIAN DATE