Cherryl A Davis, DDS, PA
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Patient Information

Today's date: _____

Date of Birth: _____ SSN#: _____

Name: _____
(last) (first) (middle)

Mailing Address: _____
Street Address City, State Zip

Physical Address: _____
(if different from mailing address)

Email:
_____@_____.com

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

Sex: (circle) Male Female Marital Status:(circle) Married Single

Employer: _____
(Business Name) (phone #)

Spouses Name: _____DOB: _____Phone#_____

Spouses Employer: _____

Emergency Contact: _____Phone#_____

Nearest Relative not living with you: _____
(name)

_____
(address) (phone)

Medical History

General History (circle): Excellent Good Fair Poor

Name and Address of Physician: _____
Date of Last Complete Physical: _____

List any surgeries in last 5 years? _____
Are you pregnant? _____If so, how far along?_____

Please list all CURRENT MEDICATIONS:
(Include all prescription and over-the-counter medicines that you are taking now)

_____

_____

Are you taking blood thinners? _____ if so, what? _____
Are you taking any medicines for bone density? _____if so, what? _____

Are you allergic to? (circle)

Penicillin Codeine Sulfa Latex

Local Anesthetic Other Medications (please list)

_____ _____

Do you have or have you ever had? (circle)

Abnormal Blood Pressure
Anemia
Angina Pectoris
Arthritis
Artificial Heart Valve
Artificial Joint
Asthma
Back Problems
Bleeding Problems
Blood Disease
Blood Transfusion
Bruise Easily
Chemotherapy (Cancer)
Cold Sores
Congenital Heart Lesions
Cortisone Medicine
Cough
Diabetes
Drug Addiction
Staph infection/MRSA
Emphysema
Epilepsy/Seizure
Fainting/Dizziness
Frequent Earaches
Frequent Headaches
Genital Herpes
Glaucoma
Hay Fever
Heart Disease/Attack
Heart Failure
Heart Murmur/MVP
Heart Pacemaker
Heart Surgery
Hemophilia
Hepatitis A, B, C
High Blood Pressure
Jaundice
Kidney Trouble
Liver Disease
Tobacco
Nervousness
Pain in Jaw Joints
Popping Jaw Joints
Psychiatric Treatment
Respiratory Problems
Rheumatism
Scarlet Fever
Seasonal Allergies
Sickle Cell Disease
Sinus Trouble
Smoker ____Packs/day
Stroke
Teeth Sensitivity
Thyroid Disease
Tuberculosis (TB)
Ulcers
Venereal Disease
X-ray/Cobalt Treatment
AIDS/ HIV Positive

Dental History

Dental Health: (circle) Excellent Good Fair Poor

Has any member of your family been treated in our office previously? Yes/No

If yes, Who? _____

Whom may we thank for referring you to our office? _____
Relationship? _____

Date of last dental visit? _____

- Are you satisfied with the appearance of your teeth? Yes No
- Would you like the opportunity to whiten your teeth? Yes No
- Are you concerned with bad breath? Yes No
- Are your teeth sensitive to hot, cold, sweet or sour food/liquids? Yes No
- Do you clinch or grind your teeth while awake or asleep? Yes No
- Have you experienced prolonged bleeding or complications following dental treatment? Yes No
- Clinical photographs that are taken pre & post op may be used for (including but not limited to): in-office display, printed materials, insurance correspondence, internet postings. Do you consent? Yes No
  (Complete facial photo nor patient names are used for public postings)

Consent:

The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment.

Signed: _____ Date: _____

Dental Insurance Information

Do you have dental insurance? (circle) Yes No

Name of Insurance Company_____

Insured/Subscriber Name: _____

ID/SSN: _____

Group or Policy #: _____

Assignment and Release:

I, the undersigned, have insurance coverage with

_____, and assign directly to
(Name of insurance company)

Cherryl A Davis, DDS PA all benefits, if otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signed _____

Date_____