SouthPark Dentistry **(+)** **(+)** Date:_____
Stuckey & Mudd DDS
This Information is confidential.

PATIENT INFORMATION

Patient Name: _____ Preferred Name: _____
Last First MI

❒Male ❒Female ❒Married ❒Single ❒Child ❒Other_____ Birth Date:_____ Social Security # _____

Phone (H): _____ (W): _____ Ext:_____ (Cell):_____

Preferred appointment times: ❒AM ❒PM ❒Any ❒M ❒T ❒W ❒T ❒F Best time to call:_____

Address: _____
Street Apartment # Email address

_____
City State Zip Code

Who may we thank for referring you to our office? _____

How are you paying for today's services or the amount insurance does not pay? ❒ Cash ❒ Check ❒ Credit Card

SPOUSE / PARENT / GUARDIAN INFORMATION

The following is for: ❒ the patient's spouse ❒ the person responsible for payment

Name: _____

❒ Male ❒ Female ❒ Married ❒ Single ❒ Other_____ Social Security #_____ Birth Date:_____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call:_____

Address: _____
Street Apartment #

_____
City State Zip Code

EMPLOYMENT INFORMATION

The following is for: ❒ the patient ❒ the person responsible for payment

Employer Name: _____ Occupation:_____

Address: _____
Street City State Zip Code

Will you receive calls at work? ❒ Yes ❒ No

INSURANCE INFORMATION

Primary

Name of Insured: _____ Is insured a patient? ❒ Yes ❒ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address_____
Street City State Zip Code

Insured's Employer Name:_____

Address:_____
Street City State Zip Code

Patient's relationship to insured: ❒ Self ❒ Spouse ❒ Child ❒ Other_____

Insurance Plan Name:_____

Address:_____
Street City State Zip Code

Secondary

Name of Insured: _____ Is insured a patient? ❒ Yes ❒ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address_____
Street City State Zip Code

Insured's Employer Name:_____

Address:_____
Street City State Zip Code

Patient's relationship to insured: ❒ Self ❒ Spouse ❒ Child ❒ Other_____

Insurance Plan Name:_____

Address:_____
Street City State Zip Code

HEALTH HISTORY

Please answer all of the questions accurately. The success of your dental treatment depends on this strictly confidential information.

Medical History

Circle One

Do you consider yourself to be in good health? ..... Yes No
Have you been examined by your physician within the last year? ..... Yes No
Are you being treated for any condition by a physician now? For what? _____ Yes No
Are you taking any medications presently? If so, please list including non-prescription. _____ Yes No
_____
Do you use any tobacco products? cigarettes, cigars, pipe, smokeless _____ Yes No
Have you ever had any complications following dental treatment? ..... Yes No
If yes, please explain:_____
Do you take aspirin on a daily basis? If so, how much? _____ Yes No
Are you allergic to any medications? (circle) Penicillin, Aspirin, Codeine, Iodine, Sulfa _____ Yes No
Do you have any health problems that need further clarification? ..... Yes No
If yes, please explain:_____

Have you ever had or been treated for any of the following? Please check or circle those that apply:

- ❒ Acid Reflux, Bulemia
- ❒ AIDS,ARC,HIV+
- ❒ Allergies-pollen,etc
- ❒ Allergies-latex,nickel
- ❒ Anemia
- ❒ Angina
- ❒ Arthritis
- ❒ Artificial Heart Valve
- ❒ Artificial Joints
- ❒ Asthma
- ❒ Blood Disease,Hemophilia
- ❒ Blood Transfusion
- ❒ Cancer,Chemotherapy
- ❒ Crohn's Disease
- ❒ Diabetes
- ❒ Dizziness
- ❒ Emphysema,Bronchitis
- ❒ Epilepsy,Seizures
- ❒ Excessive Bleeding
- ❒ Fainting Spells
- ❒ Fever Blisters,Herpes I/II
- ❒ Glaucoma,Eye Disorders
- ❒ Hay Fever
- ❒ Head Injuries
- ❒ Heart Attack,Heart Disease
- ❒ Heart Murmur
- ❒ Hepatitis A / B / C
- ❒ High Blood Pressure___/__
- ❒ Immune system
- ❒ Kidney Disease
- ❒ Liver Disease, Jaundice
- ❒ Psychiatric Treatment
- ❒ Minocycline antibiotics
- ❒ Mitral Valve Prolapse
- ❒ Nervous Disorders
- ❒ Pacemaker
- ❒ Radiation Treatment
- ❒ Respiratory Problems
- ❒ Rheumatic Fever
- ❒ Rheumatism (arthritic)
- ❒ Sinus Problems
- ❒ Stomach Ulcers
- ❒ Stroke
- ❒ Thyroid Disease
- ❒ Tuberculosis
- ❒ Tumors
- ❒ Ulcers
- ❒ Venereal Disease
- ❒ Female:currently Pregnant due date:_____
- ❒ Female:currently Nursing
- ❒ OTHER:_____

Name of Physician: _____ Phone:_____

Dental History

Have you experienced any of the following habits, symptoms or treatment? Please check those that apply:

- ❒ Pain/swelling with the teeth
- ❒ Teeth sensitive to hot/cold/sweets
- ❒ Teeth sensitive to biting pressure
- ❒ Apprehensive about dental treatment
- ❒ Periodontal (gum) treatments
- ❒ Gums that bleed or feel tender
- ❒ Bad odors or tastes in your mouth
- ❒ Child:thumb sucking
- ❒ Grind or clinch your teeth
- ❒ Jaws click or pop when you chew
- ❒ Crowded teeth
- ❒ Orthodontic treatment (braces)

Date of Last Dental Visit: _____ Reason for this visit:_____

Consent for Services

All of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the dentist at the next appointment. As a condition of your treatment by this office, financial arrangements must be made in advance. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I have been made aware of this office's *HIPAA Notice of Privacy Practices* which is displayed at the receptionist's desk. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and agree to their content.

_____ Date: _____ Relationship to Patient: (*circle*) Parent or Guardian
Signature of patient, parent or guardian