PATIENT INFORMATION AND HEALTH HISTORY

Patient Name _____ Social Security # _____
Preferred Name _____ Date of Birth _____ Age:_____
Parent or Legal Guardian Name (if minor) _____ Home Phone _____
Mailing Address _____ Cell Phone _____
Street Address _____ Place of Employment _____
City _____ State _____ Zip _____ Work Phone _____
Contact Method: ___Text Message ___Email ___Phone Call Email Address:_____
Spouse _____ Spouse Employment _____
Emergency Contact & Phone:_____

Person Responsible for this Account:
Name _____
Mailing Address _____
Place of Employment _____ Work Phone _____

Referred By _____

DENTAL INSURANCE INFORMATION

Member's Name _____ Social Security # _____
Address (if different from patient) _____
Place of Employment _____ Date of Birth _____
Dental Insurance Plan _____

DENTAL HISTORY

Date of Last Dental Exam _____ Date of Last Dental Treatment _____

MEDICAL HISTORY

Physician's Name_____ Date of Last Physical Exam _____

Do you have or have you ever had any of the following? – indicate with an (X)

( ) AIDS (or HIV Positive)
( ) Hepatitis
( ) Allergies in general
( ) Mitral Valve Prolapse
( ) Allergies to Anesthesia
( ) Any Heart Ailments
( ) High Blood Pressure
( ) Neurological Problems
( ) Radiation Treatments
( ) Excessive Bleeding
( ) Take Anticoagulants (blood thinners)
( ) Sickle Cell Anemia
( ) Drug Allergies (Please list)_____

( ) Anemia/Blood Problems
( ) Arthritis
( ) Asthma
( ) Hay Fever
( ) Diabetes
( ) Kidney Problems
( ) Liver Problems
( ) Malignancies
( ) Psychiatric Care
( ) Rheumatic Fever
( ) Heart Murmur
( ) Artificial Joints

( ) Sinus Problems
( ) Stroke
( ) Thyroid
( ) Eye Disorders
( ) Tonsillitis
( ) Tuberculosis
( ) Ulcer or Colitis
( ) Currently Pregnant
if yes, due date _____
( ) Venereal Disease
( ) Seizures
( ) Other _____

List any medications you are currently taking:_____
_____
_____

PATIENT AGREEMENT

I consent to Dr. Raanne Tindle or Dr. Trevor Tindle Hall providing dental services for the above named patient. **I understand that missed appointments or appointments canceled without 24 hour prior notification may result in a charge of $30.00 per hour**. As a courtesy, this dental office will be happy to file my insurance claim for me. However, all deductibles, co-payments and balances not paid by the insurance company will be paid by me. A finance charge of 1.75% per month (21% per annum) on any unpaid balance will be charged on all accounts exceeding 90 days. I authorize release of any information related to any insurance claims and authorize payment of the dental benefits otherwise payable to me directly to Raanne Ray Tindle, DMD, PA.

Patient's Signature _____ Date _____
(If patient is a minor, parent or guardian please sign)

Insured Member's Signature:_____ Date _____

Thank you for choosing Dr. Raanne Tindle and Dr. Trevor Tindle Hall for your dental care. We value you as our dental patient and will do our utmost to make you comfortable. We appreciate any referrals of your family and friends to our dental office.