PATIENT INFORMATION AND HEALTH HISTORY

Patient Name _____
Preferred Name _____
Parent or Legal Guardian Name (if minor) _____
Mailing Address _____
Street Address _____
City _____ State _____ Zip _____
Contact Method: ___Text Message ___ Email ____ Phone Call
Spouse _____
Emergency Contact & Phone: _____

Social Security# _____
Date of Birth _____ Age: _____
Home Phone _____
Cell Phone _____
Place of Employment _____
Work Phone _____
Email Address: _____
Spouse Employment _____

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 _____
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 _____

Have you EVER taken any medication to treat osteoporosis? _____
List any medications you are currently taking: _____

PATIENT AGREEMENT

I consent to Dr. Trevor A. Tindle and Dr. Raanne R. Tindle 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 $40.00 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 Tindle Family Dentistry PA.

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

Insured Member's Signature: _____ Date _____

Thank you for choosing Tindle Family Dentistry 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.