



DR. BRUCE O'DONOGHUE, D.D.S.

DR. JOHN DEAN, D.D.S.

DR. NATE LEWIS, D.D.S.

MICHELLE READING, R.D.H.

SHELLY J. ALLRED, R.D.H.

PATIENT INFORMATION

Patient's Name _____

Birth Date _____ Age _____ Male Female Marital Status _____

Driver's License No. _____ Social Security No. _____

Person Responsible for Account _____

Relationship _____ Social Security No. _____ Date of Birth _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Business Phone _____

Spouse's Name _____ Business Phone _____

Name of Nearest Relative _____ Phone _____

Address _____ City _____ State _____ Zip _____

How did you hear about our office? _____

PRIMARY INSURANCE INFORMATION

Insured Name _____ Social Security No. _____

Group No. _____ Insurance Co. Name _____

Address _____ City _____ State _____ Zip _____

SECONDARY INSURANCE (COMPLETE ONLY IF COVERED BY TWO INSURANCE COMPANIES)

Insured Name _____ Social Security No. _____

Group No. _____ Insurance Co. Name _____

Address _____ City _____ State _____ Zip _____

AGREEMENT FOR EXTENSION OF CREDIT

In accordance with the Federal Truth-In-Lending Act which requires all doctors to give their patients information in connection with the extension of credit, please be advised of the following policies which apply in this office. The responsible party agrees to:

1. Pay the doctor at the time treatment or service is received or by previous arrangements.

I/We agree to pay costs and reasonable attorney's fees if any delinquent account is placed with an agency or attorney for collection or suit.

Responsible Person Signature _____ Date: _____

(SEE REVERSE SIDE)

Patient's Name _____
Medical Doctor Name _____

Date of Birth _____
Phone _____

Please answer the following question as completely as possible (circle YES or NO)

1. Do you consider yourself to be in good health? YES NO
2. Are you now or have you been under a physician's care within the past year?
If YES, specify condition being treated: YES NO
3. Do you take any medications, including birth control pills?
If YES, specify name and purpose of medication: YES NO
4. Do you have, or have you ever had any heart or blood problems? YES NO
5. Have you ever been told you have a heart murmur? YES NO
6. Do you require antibiotic pre-medication for a heart condition, artificial valve, or artificial joint? YES NO
7. Do you have, or have you ever had high blood pressure? YES NO
8. Do you bleed or bruise easily? YES NO
9. Have you ever been diagnosed as being HIV positive or having AIDS? YES NO
10. Have you ever had hepatitis or liver disease? YES NO
11. Have you ever had: Rheumatic Fever Asthma any Blood Disorder Diabetes Rheumatism
Arthritis Tuberculosis Venereal Disease Heart Attack Kidney Disease
Immune System Disease Other Disease YES NO
12. Have you ever had an unusual reaction, or are you allergic to any of the following drugs: Penicillin
Aspirin Acetaminophen Ibuprofen Codeine Barbiturates Sulfa Drugs
Other YES NO
13. Are you subject to fainting? YES NO
14. Have you ever had any severe reaction to dental treatment or local anesthetics? YES NO
15. Are you allergic to any local anesthetics? YES NO
16. Do you have any other allergies? If YES, please explain YES NO
17. Have you ever had a nervous breakdown or undergone psychiatric treatment? YES NO
18. Have you ever received counseling for excessive use of alcohol and/or prescription drugs? YES NO
19. Women: Are you pregnant? YES NO
20. Are you now in pain? YES NO
21. How long ago did you last see a dentist? YES NO
22. Who was your previous dentist? YES NO
23. Do you think that your teeth are affecting your general health in any way? YES NO
24. Do you have or have you ever had bleeding or sensitive gums? YES NO
25. Have you ever taken Phen-Fen or similar appetite suppressants? YES NO
If YES, have you seen your physician or cardiologist for a cardiac evaluation? YES NO

DENTAL INFORMATION

- | | | | | | |
|-----|----|--|-----|----|---|
| YES | NO | Do you have any pain in or near your ears? | YES | NO | Do you have or have you had bleeding gums? |
| YES | NO | Do you habitually clench your teeth during the day or night? | YES | NO | Have you ever been instructed in caring for your gums? |
| YES | NO | Are any areas of your mouth sore or sensitive to sweets, hot, cold, or chewing problems? | YES | NO | Have you ever been instructed in the prevention of decay? |
| YES | NO | Any reactions or allergic symptoms to novocaine or xylocaine? | YES | NO | Have you ever had a series of full x-rays in the past year? |
| YES | NO | Any difficult extractions? Any prolonged bleeding following extractions? | YES | NO | Do you have any present dental complaints? |