

Dr. David C. Medford, D.D.S.

Orthodontic ■ Cosmetic ■ Family Dentistry

NEW PATIENT INFORMATION

Patient's Name _____
(First) (Middle) (Last)

Home Address _____ City _____ Zip _____

Phone _____ Work _____ Cell _____

Occupation _____ Employer _____

Age _____ Gender _____
DOB ____/____/____ SS# _____

Drivers License # _____
(We will need to make a copy of your license)

Email Address _____
How did you hear about us? _____

Emergency Contact _____ Phone # _____

Relationship _____

EMPLOYMENT INFO

EMPLOYER: _____ WORK PHONE: _____

INSURANCE INFORMATION

Insurance Co. Name _____

Insurance Address _____

Insurance Phone # _____ Group # _____

Insured's Name _____ Relation _____

Insured's Birthday _____ Insured's SS # _____
Insured's Employer _____

SPOUSE INFORMATION

Spouse's Name _____

Employer _____

Wk# _____ SS# _____

Birthdate _____ DL# _____

MEDICAL HISTORY

For your safety and to assist us in accurately diagnosing and treating you, please carefully review this form completely and fill out all areas that pertain to you.

Name of Physician _____

Phone # _____ Date of Last Visit _____

Your current physical health is: good, fair, poor

Are you currently under the care of a physician? Please explain

Do you smoke? No/ Yes Packs/Day? _____ Number of Years? ____

Please list ALL medications you are now taking (include over the counter drugs and vitamins): _____

If Female, are you:

Pregnant ____ Nursing ____ Taking birth control pills ____ Hormones ____

Please circle any of the following medications you are ALLERGIC to:

- | | |
|---|--|
| <input type="checkbox"/> Darvocet | <input type="checkbox"/> Lortab |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Doxycycline | <input type="checkbox"/> Versed |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Halcion |
| <input type="checkbox"/> Valium | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Vicodin |
| <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Keflex |
| <input type="checkbox"/> Tylenol | <input type="checkbox"/> Erythromycin Tetracycline Demerol |

List any other medications you are allergic to:

Please circle any of the following that you now have or have ever had:

- | | |
|---|--|
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Ankles Swell |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Frequent Thirst/Urination | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Previous Fen-Phen Use |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Artificial Knee |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Artificial Hip |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Fainting/Dizziness |
| <input type="checkbox"/> Kidney/Bladder Trouble | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Congenital Heart | <input type="checkbox"/> Lesions |
| <input type="checkbox"/> Cancer or Tumors Blood Transfusion | |

Do you have any medical condition/disease not listed above that we should know about?

DENTAL HISTORY

Previous Dentist _____ City _____

How Long _____

Date of Last Cleaning _____ Frequency of Cleanings _____

Do you brush your teeth daily _____ Manual or Mechanical Brush (circle)

Do you floss daily? Yes No

Please circle if you currently have or have had:

- | | |
|---|---|
| <input type="checkbox"/> Mouth Discomfort | <input type="checkbox"/> Previous Periodontal Treatment |
| <input type="checkbox"/> Scaling/Root Planning | <input type="checkbox"/> Orthodontic Treatment |
| <input type="checkbox"/> Gum Abscesses | <input type="checkbox"/> Bleeding Gums |
| <input type="checkbox"/> Cold Sores or Fever Blisters | <input type="checkbox"/> Mouth Odor or Bad Taste |
| <input type="checkbox"/> Loose or Shifting Teeth | <input type="checkbox"/> Other Oral Lesions/Sores |
| <input type="checkbox"/> Gum Surgery | <input type="checkbox"/> Clicking, Popping or Pain in jaw |
| <input type="checkbox"/> Grinding or Clenching Your Teeth | |
| <input type="checkbox"/> Sensitive Teeth (Hot, Cold, or Sweets) | |

Reason for your visit today? _____

Do You Want to Keep Your Teeth?

___ Yes, no matter what it takes

___ Don't Know

___ Yes, if it is not too much trouble

___ Don't Care

Are you happy with your smile? ___ Yes ___ No

If not, what would you change?

CONSENT

- I attest that to the best of my knowledge, the information provided is accurate and complete. Any changes in health status or medications will be reported to the Doctor.
- I authorize the Doctor or his representatives to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis and to develop proper recommendations for (name of patient) _____'s treatment.
- I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy indicated after all my questions have been answered.
- Scheduling an appointment is interpreted as authorization for treatment. I also understand that the use of anesthetic agents embody certain risks.
- I also acknowledge that I have received a copy of the office's Notice of Privacy Practices either in written form or from the website.

Patient Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

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OFFICE FINANCIAL POLICY

Please take a moment to read over our office policies
(Please initial next to each policy)

- **CANCELATION OF APPOINTMENTS** is required 24 hours in advance or the patient is responsible for a \$50 broken appointment fee. Please understand that leaving a message after the office is closed for the day (or the weekend) before an appointment is not sufficient enough. ____

- **INSURANCE** Often there are charges beyond what insurance will cover. As a service to our patients, this office will file insurance claims on their behalf; however, I understand that what may be quoted as my portion (co-payment) is only an estimate. Your insurance coverage is an agreement between you and your insurance company. We agree to file claims for contracted carriers per our agreement with your carrier. Most misunderstandings regarding insurance benefits can be avoided if you are aware of your specific policy guidelines. This practice treats by medical necessity, and not what your insurance company will cover. If your insurance company chooses not to pay for any reason or if they choose to delay payment, you will be responsible. Any payments not received by your carrier within 60 days of the claim filing will be your responsibility. I agree to be financially responsible for what insurance does not cover, and my co-payment is due at the time service is rendered, and any further balance not covered by insurance will be due upon receipt of notice. _____

- **DELINQUENT ACCOUNTS:** Should your account become delinquent for nonpayment, you will be reported to the collection service. Accounts must be current before future appointments may be scheduled. _____

- **RETURNED CHECKS:** A \$30.00 NSF fee will be applied to all returned checks. If restitution is not made in a timely manner, we will seek prosecution by the District Attorney. _____

I understand and accept the terms of this financial policy:

Patient Signature: _____ Date: _____