PERSONAL INFORMATION:

TODAY'S DATE_____

REFERRING DENTIST OR PERSON_____

PATIENT'S NAME_____BIRTH DATE_____S/S #_____

PATIENT'S WEIGHT_____MALE or FEMALE_____PARENT'S NAME (if patient is a minor)_____

PHONE: H.(___)_____W.(___)_____EXT_____CELL(___)_____E-Mail:_____

STREET/MAILING ADDRESS_____CITY_____ST_____ZIP_____

MARITAL STATUS_____EMPLOYER OR RETIRED FROM_____

OCCUPATION_____NEAREST RELATIVE NOT LIVING WITH YOU_____

RELATION_____ADDRESS_____PHONE_____

PERSON RESPONSIBLE FOR PAYMENT (IF OTHER THAN PATIENT): NAME_____

RELATION_____S/S #_____BIRTH DATE_____PHONE(___)_____

DENTAL INSURANCE INFORMATION: PRIMARY DENTAL COVERAGE: Y N SECONDARY INS. COVERAGE: Y N

EMPLOYEE'S NAME_____RELATION_____BIRTH DATE_____S/S #_____

ADDRESS (if different than patient)_____

EMPLOYER (even if retired)_____GROUP # _____

INS. CO._____PHONE(___)_____ADDRESS_____

We are not a dental provider for all insurance companies - For these, you will need to pay us in full at the time of your procedure.

In order to process your insurance, we will need to have a copy of your dental insurance card and a photo ID.

I certify that I have dental coverage with _____Insurance Company and I assign directly to Dr. MacIntyre all insurance benefits, otherwise payable to me. I hereby authorize Dr. MacIntyre to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____

Signature of Insured Date

Payment is due at the time services are rendered. We accept cash, checks and all major credit cards. Returned checks will be subject to a $35.00 service charge. If you have any questions about any of the information, please don't hesitate to ask us. We are here to help you and we are committed to providing you with the best possible care. **If you fail to keep your appointment, you will be charged a $75.00 fee. If you do not confirm your appointment in advance, your appointment will be given to the next patient on our list.**

I understand and agree that regardless of my insurance status, I am responsible for the balance on my account for any professional services rendered. I have read all of the information on both sides of this sheet and have answered the questions. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

_____ _____

Signature of patient (or parent if patient is under 18 years of age) Date

CONTINUE ON BACK FOR MEDICAL INFORMATION

ARE YOU PRESENTLY EXPERIENCING ANY DISCOMFORT IN YOUR TEETH? Y N

EXPLAIN_____

IS THIS THE RESULT OF AN ACCIDENT? Y N EXPLAIN_____

HAVE YOU EVER HAD SERIOUS PROBLEMS WITH ANY PREVIOUS DENTAL TREATMENT? Y N

EXPLAIN_____

MEDICAL HISTORY: DATE OF LAST PHYSICAL EXAM_____PHYSICIAN'S NAME_____

ARE YOU NOW OR HAVE YOU BEEN RECENTLY UNDER A PHYSICIAN'S CARE? Y N

EXPLAIN_____

HAVE YOU EVER BEEN HOSPITALIZED OR HAD A SERIOUS ILLNESS IN THE PAST FIVE YEARS? Y N

EXPLAIN_____

ARE YOU CURRENTLY TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING MEDICATIONS? PLEASE CIRCLE

ANTIBIOTICS	**CORTISONE DRUGS**	**STEROIDS**	**TRANQUILIZERS**
BLOOD PRESSURE	**BLOOD THINNERS**	**SEDATIVES**	**OTHERS**_____

ARE YOU ALLERGIC TO OR HAVE YOU EXPERIENCED AN UNUSUAL REACTION TO ANY MEDICATIONS? PLEASE CIRCLE

PENICILLIN	**CODIENE**	**ASPIRIN**	**SULFA**
DENTAL ANESTHESIA	**LATEX**	**OTHERS**_____	

HAVE YOU EVER BEEN TOLD TO TAKE ANTIBIOTICS *BEFORE* ANY DENTAL TREATMENT? Y N

IF YES, WHAT ANTIBIOTICS DO YOU TAKE?_____

WOMEN ONLY: ARE YOU PREGNANT? Y N UNSURE IF YES, WEEKS OR MONTHS#_____BREASTFEEDING? **Y N**

TAKING BIRTH CONTROL PILLS, SHOTS, IMPLANT OR HORMONE THERAPY? EXPLAIN_____

_____

ANSWER ALL OF THE BELOW:	**(Y) YES**	**(N) NO**	**(DK) DON'T KNOW**

ABNORMAL BLEEDING	**Y N DK**	**HIGH OR LOW BLOOD PRESSURE (WHICH ONE)**	**Y N DK**
ANEMIA	**Y N DK**	**HIV+/AIDS**	**Y N DK**
ARTHRITIS	**Y N DK**	**HIVES (CAUSE)** _____	**Y N DK**
ARTIFICAIL JOINTS	**Y N DK**	**INFECTIVE ENDOCARDITIS**	**Y N DK**
ASTHMA OR HAY FEVER	**Y N DK**	**KIDNEY OR BLADDER PROBLEMS**	**Y N DK**
BLOOD DISEASE OR TREATMENT	**Y N DK**	**LIVER PROBLEMS**	**Y N DK**
CANCER OR TUMOR	**Y N DK**	**LUNG DISEASE**	**Y N DK**
CHEMO OR RADIATION THERAPY	**Y N DK**	**PERSISTENT COUGH**	**Y N DK**
CHEST PAIN	**Y N DK**	**SEIZURES**	**Y N DK**
DIABETES (INSULIN OR MEDS)	**Y N DK**	**SINUS PROBLEMS**	**Y N DK**
DIFFICULTY BREATHING	**Y N DK**	**STEROID THERAPY**	**Y N DK**
EPILEPSY	**Y N DK**	**STROKE**	**Y N DK**
FAINTING SPELLS	**Y N DK**	**THYROID PROBLEMS**	**Y N DK**
GLAUCOMA	**Y N DK**	**TUBERCULOSIS (TB)**	**Y N DK**
HEART TROUBLE	**Y N DK**	**ULCERS**	**Y N DK**
HEPATITIS TYPE_____	**Y N DK**	**SEXUALLY TRANSMITTED DISEASE**	**Y N DK**
HERPES, SHINGLES, ZOSTER (WHICH ONE)	**Y N DK**	**OTHER**_____	

PLEASE LIST ANY SERIOUS MEDICAL CONDITION(S) YOU HAVE EXPERIENCED THAT HAS NOT BEEN ASKED_____

_____

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