Patient Information

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please print)

Name_______________________________________ Date__________ SS#______________

First MI Last

Address______________________________ City________________ State_____ Zip__________

Birthdate_______________ Home Phone#_______________ Work Phone#_______________

Cell Phone#_______________ Pager#_______________

Do you prefer to receive call at: Home _____ Work _____ Either _____

Are you: Minor ____ Married ____ Divorced ____ Widowed ____ Single ____ Separated ____

You or your parent's employer_____________________________ Occupation______________

Business Address____

Spouse or parent's name_______________ Workplace________________ Work#__________

If you are a student, name of school/college____

Whom may we thank for referring you to us?____

Person to contact in case of emergency____

Relationship to you____________________ Phone #______________________

Responsible Party

Name of person responsible for this account?_______________________________________

Relationship to patient__________________ Phone#_______________________________

Address______________________________ City________________ State_____ Zip_______

Name of employer_______________________________ Work phone#_________________

Insurance Information

Name of insured____________________________ Relationship to patient________________

Birthdate___________________ SS#____________________________

Name of employer_______________________________ Work phone#_________________

Address____

Insurance Co. Address____

Group#______________________

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? Yes_____ No_____

If yes, please complete the following:

Name of insured____________________________ Relationship to patient________________

SS#___________________ Birthdate__________________ Insurance effective date________

Name of employer_______________________________ Work phone#_________________

Insurance Co.___________________________________ Group#_____________________

Insurance Co. Address____

Dental History

Former Dentist____

Reason for today's visit____

What would you change about your smile?_____________________________________

Date of last exam________________________ Date of last dental x-rays________________

Please check any of the following conditions that apply to you:

Bad breath_____ Grinding teeth_____ Sensitivity to hot or cold_____

Bleeding gums_____ Loose teeth or broken fillings_____ Sensitivity to sweets_____

Clicking or popping jaw_____ Periodontal treatment_____ Sensitivity when biting_____

Medical History

Physician______________________________________Date of last visit____________________
Please list all medications you are currently taking______________________________________
Allergies____
(Women) Are you pregnant? Yes_____ No_____ Taking birth control pills? Yes_____ No_____

Do you have a history of the following:

Aids, Anemia, Arthritis, Rheumatism
Artificial Heart Valves, Artificial Joints, Asthma, Back Problem
Cancer, Chemical Dependency, Chemotherapy
Circulatory Problems, Cortisone Treatments, Persistent Cough
Diabetes, Epilepsy, Fainting, Glaucoma, Headaches
Heart Murmur, Heart Problems (Describe)____________________________
Hemophilia, Hepatitis, High Blood Pressure, HIV Positive
Jaw Pain, Mitral Valve Prolapse, Nervous Problems
Pacemaker, Psychiatric Care, Radiation Treatment
Respiratory Disease, Rheumatic Fever, Scarlet Fever
Shortness of Breath, Stroke, Swelling of Feet or Ankles
Thyroid Problems, Tobacco Habit, Tuberculosis, Ulcer, Venereal Disease

Financial Responsibility and Consent to Treatment

- **Payment is expected as services are rendered, unless prior arrangements are made**
- **For your convenience, we accept Visa, MasterCard and Discover**
- **Appointments broken without notice will incur a minimum $20 charge**
- **We require 50% down on all work involving laboratory services**

In consideration of the dental consultation and/or services to be provided to me or a member of the family, I agree to make payment for services rendered. I understand that any contract for dental insurance coverage is a separate contract between you and your insurance company. In the event of non-payment or non-coverage by dental insurance, I agree that I am ultimately responsible for all charges on my account. In the event that this account is turned over to an attorney for collection, I agree to make payment of all costs of collection, legal expenses and reasonable attorney's fees incurred by H. Ross Morrison, DDS, PC.

Signature of Patient (or parent if minor)__________________________________
Date:__________________

Update

Date	Initial
_______	_____
_______	_____
_______	_____
_______	_____
_______	_____
_______	_____