JAMES SEAVER D.D.S., TYLER PITTMAN D.D.S., P.C. and MICHAEL CAGLE D.D.S.

PATIENT INFORMATION:

Patient Name: _____ **Date of Birth:**_____
First Middle Last **SS#:** _____
Mailing Address: _____ **Home Phone:** ( )_____
Street **Work Phone:** ( ) _____
_____ **Cell Phone:** ( )_____
City State Zip

Place of Employment (or School): _____ **E-mail**: _____

DL #: _____ **Emergency Contact Name:** _____

Emergency Contact Phone #: _____**Relationship to patient:**_____

DENTAL HISTORY:

When was your last dental check up? _____ When were your last cavity detection x-rays taken? _____
Full mouth dental x-ray? _____ Number of times a day you brush your teeth: _____
Do you floss? _____ Do your gums bleed when you brush? _____ Have you been diagnosed with periodontal disease? _____ Are your teeth sensitive to: ( ) Cold ( ) Hot ( ) Sweets
Do you clench or grind your teeth? ____ Do you wake up with jaw pain? ____Does your jaw click? ____
Are there specific oral health issues that you would like to discuss at this visit? _____

PLEASE MARK Y (YES) TO ALL OF THE FOLLOWING THAT APPLY:

Y	**Y**	**Y**	**Y**
__ Abnormal Bleeding	__ Heart Attack	__ Tuberculosis	**ALLERGIES:**
__ Alcohol Abuse	__ Heart Murmur	__ Ulcers	__ Aspirin
__ Allergies	__ Heart Surgery	__ Venereal Disease	__ Codeine
__ Arthritis	__ Hepatitis A	__ Anemia	__ Dental Anesthetics
__ Artificial Bones	__ Hepatitis B OR C	__ Angina Pectoris	__ Jewelry
__ Artificial Heart Valve	__ High Blood Pressure	__ Colitis	__ Metals
__ Asthma	__ Kidney Problems	__ Cosmetic Surgery	__ Latex
__ Blood Transfusion	__ Liver Disease	__ Emphysema	__ Penicillin
__ Bruise Easily	__ Low Blood Pressure	__ Glaucoma	__ Keflex
__ Cancer-Chemotherapy	__ Mitral Valve Prolapse	__ Hay Fever	__ Sulfa Drugs
__ Congenital Heart Defect	__ Pace Maker	__ Hemophilia	__ Tetracycline
__ Dental Implants	__ Pain in Jaw Joints	__ Night Sweats	__ Erythromycin
__ Diabetes	__ Rheumatic Fever	__ Pneumocystitis	
__ Difficulty Breathing	__ Seizures	__ Psychiatric Problems	__ Clindamycin
__ Drug Abuse	__ Sinus Problems	__ Smoke or use of Tobacco	
__ Epilepsy	__ Stroke	__ Pregnant/Trimester ____ Weeks _____	
__ Fainting Spells	__ Taken Fen-Phen	__ Bisphosphonates	
__ Fever Blisters	__ Taken Redux	__ Joint Replacement (How long ago _____)	
__ Frequent Headaches	__ Thyroid Problems	__ Do you have sleep apnea?	
__ HIV & AIDS		__ Do you wear a CPAP?	

Other conditions) not listed: _____
Are you under the care of a Physician? Physician Name: _____
For what Condition? _____ Are you taking any medications? (Include over the counter medications):_____
Name preferred pharmacy? _____ Phone #: _____
Are you taking Birth Control Pills?_____
Have you in the past had to pre-medicate with antibiotics before dental visits?
How did you hear about our office? ( ) Phone Book ( ) Personal Recommendation ( ) Newspaper ( ) Other
Whom may we thank for referring you to our office: _____

OUR OFFICE POLICY FOR CANCELING AND CONFIRMING APPOINTMENTS:
It is the practice in our office to provide every patient and the treatment they need the special attention deserved. Our office does not overbook patient appointments; however, we will **DOUBLE BOOK** any *unconfirmed appointment*. So that we can accommodate all our patients' needs, we ask that you provide us 24 hours notification if you are unable to keep a scheduled appointment. The office staff will attempt to contact you to remind you of your appointment. If we are unable to reach you one business day before your appointment by 2PM on a Monday - Thursday or 11AM on a Friday, it is considered an unconfirmed appointment and will be taken off our schedule. Please provide us the phone numbers where we can best reach you or leave a message during daytime hours.

RESPONSIBLE and/or INSURANCE PARTY:
Employee Name: _____
SS# _____
Date of Birth: _____
Relationship to Patient: _____
Employer: _____
Insurance Company: _____
ID Number: _____
Group Number: _____

RESPONSIBLE and/or INSURANCE PARTY:
Employee Name: _____
SS# _____
Date of Birth: _____
Relationship to Patient: _____
Employer: _____
Insurance Company: _____
ID Number_____
Group Number: _____

For patients under 18 and under we need information of a Parent or Legal Guardian, if not listed above:

Name of Parent or Guardian: _____ Date of Birth: _____
Relationship to Patient: _____ SS#: _____
Phone #: _____

In consideration of professional services performed by James M. Seaver, D.D.S. and Tyler L. Pittman, D.D.S, P.C., the undersigned hereby accepts total and absolute responsibility for all costs incurred as a result of such treatment and services not covered by any acceptable insurance. In the event of default in the payment of any amount due, after thirty days, the undersigned agrees to pay a services charge in an amount not exceeding 1.8% per month on this account. Further in the event this account is referred to an attorney or collection agency, the undersigned agrees to pay reasonable attorney fees, but in no case less than $100.00, or collections fees and court costs as permitted by laws governing these transactions.

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures (such as X-rays + fluoride treatment) as may be necessary for proper dental diagnosis and care. The information on this page and the medical history are correct to the best of my knowledge.

I have read and understand the above stated policies and completed this questionnaire accurately and completely.

SIGNATURE OF RESPONSIBLE PARTY:

X _____ Date: _____
Adult Patient - Father (or Husband) - Mother (or Wife) - Guardian

_____ History Update(s): _____
Social Security Number _____