Welcome! Thank you for selecting our office for your dental treatment! We will strive to provide you with the best possible care. To help us meet all of your dental needs; please fill out this form completely in ink. Your signature is required in the boxed areas on back of this form. If you have any questions, or need assistance, please ask.

PATIENT INFORMATION (CONFIDENTIAL)

Date: _____ PT# _____

Name _____ ☐ Male ☐ Female
First Middle Last

Preferred Name _____ Date of Birth _____

Social Security Number _____ Drivers License No. _____

Address _____

City _____ State _____ ZIP _____

Employer: _____ Occupation: _____

Check (✓) appropriate box: ☐ Married ☐ Single ☐ Child

Home Phone (____) _____ Work Phone (____) _____ Pager (____) _____

Cellular Phone (____) _____ E-Mail _____

Spouse's Name (if child, parents name) _____
First Middle Last

Spouse's Social Security Number: _____ Spouse's Date of Birth: _____

Spouse's Employer: _____ Occupation: _____

Spouse's Work Number: (____) _____ Length of Employment: _____

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone Number _____

Have you or other family members been a patient here before? ☐ YES ☐ NO
If yes, who, and when _____

Whom may we thank for referring you? _____

Name of Physician _____ Phone Number _____

INSURANCE INFORMATION

DO YOU HAVE DENTAL INSURANCE? ☐ YES ☐ NO
DO YOU HAVE DUAL DENTAL COVERAGE? ☐ YES ☐ NO

PRIMARY INSURANCE

Name of Insurance _____

Name of Insured _____

Relationship to Patient _____

Soc. Sec. No. _____

Date of Birth _____

Employer _____

Business Address _____

Business Phone _____

Length of Employment _____

Group No./Local Union # _____

SECONDARY INSURANCE

Name of Insurance _____

Name of Insured _____

Relationship to Patient _____

Soc. Sec. No. _____

Date of Birth _____

Employer _____

Business Address _____

Business Phone _____

Length of Employment _____

Group No./Local Union # _____

MEDICAL HISTORY

Check (✓) appropriate box for the following:

AIDS	☐ YES	☐ NO	Epilepsy	☐ YES	☐ NO	Pacemaker*	☐ YES	☐ NO
Anemia	☐ YES	☐ NO	Fainting	☐ YES	☐ NO	Phen-Fen Use	☐ YES	☐ NO
Arthritis, Rheumatism	☐ YES	☐ NO	Glaucoma	☐ YES	☐ NO	Psychiatric Care	☐ YES	☐ NO
Artificial Heart Valve*	☐ YES	☐ NO	Headaches	☐ YES	☐ NO	Radiation Treatment	☐ YES	☐ NO
Artificial Joints	☐ YES	☐ NO	Heart Murmur*	☐ YES	☐ NO	Respiratory Disease	☐ YES	☐ NO
Asthma	☐ YES	☐ NO	Heart Disease	☐ YES	☐ NO	Rheumatic Fever*	☐ YES	☐ NO
Back Problems	☐ YES	☐ NO	Hemophilia	☐ YES	☐ NO	Shortness of Breath	☐ YES	☐ NO
Blood Disease	☐ YES	☐ NO	Hepatitis	☐ YES	☐ NO	Skin Rash	☐ YES	☐ NO
Cancer	☐ YES	☐ NO	High Blood Pressure	☐ YES	☐ NO	Stroke	☐ YES	☐ NO
Chemical Dependency	☐ YES	☐ NO	HIV Positive	☐ YES	☐ NO	Thyroid Problems	☐ YES	☐ NO
Chemotherapy	☐ YES	☐ NO	Jaw Pain	☐ YES	☐ NO	Tobacco Habit	☐ YES	☐ NO
Circulatory Problems	☐ YES	☐ NO	Kidney Disease	☐ YES	☐ NO	Tuberculosis	☐ YES	☐ NO
Cough Up Blood	☐ YES	☐ NO	Liver Disease	☐ YES	☐ NO	Ulcers	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO	Mitral Valve Prolapse*	☐ YES	☐ NO	Venereal Disease	☐ YES	☐ NO
Emphysema	☐ YES	☐ NO	Nervous Problems	☐ YES	☐ NO			

Comments: _____

Have you been hospitalized in the last two years? ☐ YES ☐ NO

If yes, please specify _____

Have you ever had a blood transfusion? ☐ YES ☐ NO

If yes, give approximate date _____

(Women) Are you pregnant? ☐ YES ☐ NO Nursing? ☐ YES ☐ NO

Taking birth control pills? ☐ YES ☐ NO

*Usually requires Prophylactic Antibiotic before treatment.

ALLERGIES

Have you ever had an allergic reaction to any drug? ☐ YES ☐ NO

If yes, please specify _____

MEDICATIONS

List medications your are currently taking and why: _____

_____

_____

DENTAL HISTORY

Are you in Pain? ☐ YES ☐ NO

Reason for today's visit? _____

Date of last dental visit _____ Date of last cleaning? _____ Date of last X-rays? _____

Check (✓) if you have had any of the following:

☐ Bad Breath
☐ Bleeding Gums
☐ Clicking or Popping Jaw
☐ Food Collection between Teeth
☐ Grinding Teeth
☐ Loose Teeth
☐ Sores or Growths in your Mouth
☐ Tooth Sensitivity
☐ Injury to Face or Jaw

Have you had previous Periodontal Treatment? ☐ YES ☐ NO

If yes, by whom and when? _____

The above medical information is correct to the best of the patient's knowledge.

X _____ _____

Patient/Guardian Signature Doctor's Signature- Reviewed

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the office of Dr. Kevin Calvert. I authorize the office of Dr. Calvert to release all information necessary to secure the payment of benefits

We do require definite financial arrangements prior to major treatment. Each fee is individual with the patient. For those patients with insurance, we will be happy to assist you with the billing, and with any problems that may arise. However, as your insurance is a contract between you and the insurance company, fees, allowances, and coverage's are based on this contract; therefore, **THE PATIENT IS PERSONALLY RESPONSIBLE FOR ANY AMOUNT NOT PAID BY THEIR INSURANCE CARRIER.**

X _____

Signature of patient (parent if minor) **Date**