

Patient Information

Today's Date __/__/__ Patient Birthdate __/__/__

Title: Mr. Mrs. Miss Ms. Dr.

First _____ Middle _____ Last _____

Address _____

City _____ State _____ Zip _____

Telephone: Home _____ Work _____ Ext. _____

Cellular _____ Do you have text messaging? Yes No

Email: Home _____ Work _____

Do you wish to participate in e-mail or text messaging appointment reminders?

Email: Yes No Text: Yes No

(You will receive a message via email or text asking you to opt into the program.)

Gender: Female Male Status: Single Married Child

Social Security Number ____-____-____ (Parent's SS# if Minor Child)

Occupation _____ Employer _____

Emergency Contact:

Name _____ Relationship _____

Telephone Number _____

Address _____

City _____ State _____ Zip _____

Financial Responsibility Information for Dr. W. Scott Hendricks, D.D.S.:

I understand that I am responsible for all fees incurred regardless of insurance coverage.

X _____

Signed (Patient or Parents of Minor Child)

Health History

Do you have or have you ever had the following (Y for yes, N for no):

- | | |
|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cardiac Pacemaker |
| <input type="checkbox"/> Heart Problem | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Infective Endocarditis | <input type="checkbox"/> Leaky Heart Valve |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Systemic Lupus | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> HIV or AIDS |
| <input type="checkbox"/> Attention Deficit Disorders | <input type="checkbox"/> Hemophilia/Blood Disorders |
| <input type="checkbox"/> Prolonged Healing | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Immunosuppression | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Do you Smoke? | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Do you have Ear Pain? | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Artificial Joints | If yes, When? _____ |
| <input type="checkbox"/> Infected Artificial Joint | |
| <input type="checkbox"/> Women, are you pregnant? | |

Please List All Current Medications _____

Please List All Food Allergies _____

(Health History Continued)

Please List All Allergies to Metals _____

Please List All Medication Allergies _____

Are You Allergic to Latex? _____

Physician's Name _____ Telephone _____

Family Health History

Please indicate which family members (blood relatives only) have the following medical conditions (Mother, Father, Siblings, Children):

High Blood Pressure _____

Heart Disease _____

Stroke _____

Diabetes _____

Rheumatoid Arthritis _____

Alzheimer's Disease _____

Dependent Child Information

This section must be completed if under 18 or a full time student. Responsible party information is required.

Mother:

Name _____ Birthdate __/__/__

Address _____

City _____ State _____ Zip _____

Telephone: Home _____ Work _____ Ext. _____

Cellular _____

Occupation _____ Employer _____

Social Security Number ___-___-____

Father:

Name _____ Birthdate __/__/__

Address _____

City _____ State _____ Zip _____

Telephone: Home _____ Work _____ Ext. _____

Cellular _____

Occupation _____ Employer _____

Social Security Number ___-___-____

Insurance Information

Today's Date __/__/__

Insurance Subscriber Birthdate __/__/__

Insurance Subscriber Name:

First _____ Middle _____ Last _____

Subscriber Relationship to Patient:

___Self ___Husband ___Wife ___Mother ___Father

Subscriber Social Security Number ___-___-_____

Insurance Company Name _____

Group Plan Name _____

Subscriber ID _____

Insurance Company Address _____

City _____ State _____ Zip _____

Insurance Company Telephone Number _____

AUTHORIZATION TO PAY BENEFITS:

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DENTAL OFFICE OF DR. W. SCOTT HENDRICKS, D.D.S. FOR SERVICES RENDERED. I UNDERSTAND I AM RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE.

X _____

Signed (Patient or Parents of Minor Child)

Your signature will be maintained as 'signature on file' so that you do not have to sign insurance forms after each visit.

Welcome to Our Practice!